SUICIDE SCREENING IN MEDICAL SETTINGS SCREENING FOR SUICIDALITY IN MEDICAL SETTINGS: A REVIEW OF BEST PRACTICES THE CULTURALLY-GROUNDED INTERPERSONAL MODEL FOR SUICIDE ASSESSMENT

By

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Abstract

Suicide assessment training is essential for medical providers because patients are more likely to present at medical clinics than behavioral health clinics when suffering from suicidal ideation (Ahmedani et al., 2014; Luoma, Martin, & Pearson, 2002), and the range in symptom presentation complicates suicide screening (Ghasemi, Shaghaghi, & Allahverdipour, 2015; Giddens, Sheehan, & Sheehan, 2014). Using a survey from the Fairbanks Wellness Coalition (Goldstream Group Incorporated, 2017), a literature review, and three phases of evaluation from prior presentations, this webinar project supports the training needs of medical providers in the Fairbanks North Star Borough. The results from the literature review and feedback from the presentations created the content for the training. Combining suicide risk measurements with clinical judgment is best practice when assessing patients for suicide risk (Bouch & Marshall, 2005; Chung & Jelic, 2015). Use of the C-SSRS and improving clinical judgment with the Culturally-Grounded Interpersonal model for Suicide Assessment (C-GIMS) may improve results. C-GIMS incorporates new findings in the literature after the C-SSRS was created while addressing the need for perspective-taking and cultural attunement for improved clinical judgment. The purpose of this project was to train medical providers to improve screening for suicide risk in medical settings.

Keywords: suicide/suicidal ideation, medical providers, screening, assessment, training

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Screening for Suicidality in Medical Settings: A Review of Best Practices and the Culturally-Grounded Interpersonal Model for Suicide Assessment

Medical providers serve as an important point of intervention for suicide because they are uniquely situated to save someone's life (Ahmedani et al., 2014; Doherty & DeVylder, 2016; Taliaferro, Oberstar, & Borowsky, 2012). In an international study, researchers estimated that one in three people who died by suicide saw a general physician in the month preceding their death (Houston, Hawton, & Shepperd, 2001). In another study conducted in the United States of America (USA) and the United Kingdom (UK), 23% of people aged 35 years and younger and 58% of people aged 55 years and older visited a general physician during the month preceding their death (Luoma et al., 2002). Meanwhile, Ahmedani and colleagues (2014) reported 83% of patients ($N = 5894$) who died by suicide received health care services in the year prior to death, and that half of those patients did not have a mental health diagnosis in the year prior to dying by suicide.

Research indicates there is a high prevalence of deaths by suicide in the state of Alaska and in particular, a disparate number of people who identify as Alaska Native are dying by suicide. Among ethnic minority groups, people who identify as IN/AN have a disproportionately high prevalence of dying by suicide compared to people who identify with other minority populations (Leavitt et al., 2018). The National Death Reporting System data on suicide rates for people who identify as Indigenous Native/Alaska Native (IN/AN) was 21.5 deaths by suicide per 100,000 people (Leavitt et al., 2018). The state of Alaska ranked fourth in the nation for deaths by suicide; and, for people between 10-24 years of age, suicide was the leading cause of death [American Foundation for Suicide Prevention (AFSP), 2020]. The suicide rate in Alaska was nearly double the national suicide rate at 14.0 versus 27.11 cases per 100,000 people [Alaska Department of Health and Human Services, State of Alaska Epidemiology (AK DHHS,

Epidemiology), 2019; AFSP, 2020]. On a local level, in an eight-year time span from 2008 through 2015, 148 deaths from suicide were documented in the Fairbanks North Star Borough (Alaska Health Analytics & Vital Records, 2016).

To address the high rates of suicide in the Fairbanks North Star Borough, the Fairbanks Wellness Coalition (FWC) commissioned Goldstream Group Incorporated to conduct a survey in 2016 with medical providers in the Fairbanks North Star Borough. The Goldstream Group recorded medical providers' attitudes and perceptions regarding the early intervention screening of adolescent and young adult patients and identified local training needs among medical providers (Goldstream Group Incorporated, 2017). They reported that medical providers in the Fairbanks North Star Borough ($N = 44$) believed they could be effective at preventing suicide for adolescents and young adults. More than 65% of medical providers thought their actions had the potential to prevent suicide (Goldstream Group Incorporated, 2017). Less than 43% of medical providers believed they were trained to screen adolescent patients (15-17 years of age) or young adult patients (18-24 years of age) for suicide risk. Additionally, only 32% of medical providers believed they had clear guidelines for screening patients for suicide risk.

Results of the medical providers' screening survey were (a) providers were informed about the statistics of deaths by suicide, (b) they were familiar with the associated risk factors and warning signs, and (c) this knowledge was not enough. Beyond statistics and risk factors, medical providers needed a way to conceptualize a patient's risk of dying by suicide, a screening tool with high validity (to limit false positives and false negatives), and a tutorial on how to screen for suicide using an interpersonal and culturally-appropriate approach. Each section should be conveyed in a concise, memorable, and innovative way for medical providers, who may be weary of standard suicide training programs.

Methodology

The results of the aforementioned medical provider survey influenced the proposed question for this research project, which was intended to inform the content and development of a continuing medical education (CME) training webinar for medical providers to screen effectively in their practices. The research question that directed this research project was: What do medical providers need to know in order to improve screening for suicide in their practices? A literature review was conducted while simultaneously creating the webinar, "An Interpersonal Approach When Screening for Suicidality in Medical Settings: A Review of Best Practices." The literature review was an exploratory process as sources built upon each other and merged organically. Through this process, gaps in the literature were identified.

Literature review methodology. The literature review began with several references from a committee member, Heather Dahl, Ph.D. The articles suggested to review were recent articles related to medical providers and suicide. Recent contributions to the field of suicidology were assessed by reading *Advancing the Science of Suicidal Behavior: Understanding and Intervention* (Lamis & Kaslow, 2015) and *The American Psychiatric Publishing Textbook of Suicide Assessment and Management* (Simon & Hales, 2012). This author noted cross-referenced works to increase the depth of knowledge on the topic of suicidality. Next, the Rasmuson Library at the University of Alaska Fairbanks (UAF) QuickSearch feature was accessed to complete a discovery search of the UAF Library Catalog, approximately 95% of UAF Library databases. The exceptions were the ProQuest databases and Westlaw database. To find the latest studies, the QuickSearch was restricted to academic peer-reviewed articles and the names of several of the contributing authors from the two books listed above. In addition, this author read articles that were cited by multiple researchers to identify cutting-edge contributions to the field of suicidality.

Classical works from different academic domains were discerned by reading important contributions referenced by the contributing authors from *Advancing the Science of Suicidal Behavior: Understanding and Intervention* (Lamis & Kaslow, 2015) and *The American Psychiatric Publishing Textbook of Suicide Assessment and Management* (Simon & Hales, 2012). Finding classical works from different academic domains offered a breadth of knowledge in the field of suicidality. For example, Joiner's (2005) *Interpersonal Theory of Suicide* and Pope's (1976) *Durkheim's Suicide Analyzed* originate from the academic domains of psychology and sociology, respectively. The sociologist, Emile Durkheim (1897/1951), was cross-listed in a psychology article about "hidden ideators," people who identify with a minority group who do not disclose suicidal ideation (Morrison & Downey, 2000; Pokorny, 1992) due to cultural differences in expression of suicide (Chu, Goldblum, Floyd, & Bongar, 2010).

There appeared to be relationships between hidden ideation, cultural differences, and Durkheim's theory of suicide for sociology. This author either integrated or discarded the connections and relationships based on the literature review. Thus, the exploratory nature of this literature review increased the author's knowledge about suicide while intuitively leading the author to identify gaps in the literature. To remain abreast of the changing field of suicidality and to further integrate new findings into the research project, the author enrolled to receive the SAMHSA and Suicide Prevention Resource Center (SPRC) newsletter with the most current research in the field of suicidality and the State of Alaska Department of Health and Social Services, Epidemiology bulletins that support the development of local knowledge in Alaska. Feedback from three separate presentations of "An Interpersonal Approach When Screening for Suicidality in Medical Settings: A Review of Best Practices" provided insight from the audience about suicide in the Fairbanks North Star Borough, which was integrated into the ongoing literature review and webinar development.

Attending two webinars, which included the North Star Behavioral Health Suicide Screening in the Medical Setting webinar on March 27, 2018, and the Substance Abuse and Mental Health Services Administration (SAMHSA) Minority Fellowship Program Suicide Prevention Webinar held on Wednesday, February 27, 2019—provided examples of training material. The first webinar indicated that pediatricians needed a screening measurement and emphasized the importance of engaging the audience. The second webinar indicated that patients experiencing suicidal ideation are not always understood by medical providers. A medical doctor also clarified that communication was an important part of the screening process. They described how ambiguous communication or words about suicidal ideation can lead to misunderstandings.

The medical provider confirmed a hypothesized gap in the literature as practical guidance for medical providers on culturally-competent screening for suicide risk was lacking from the current literature. Chu and colleagues (2018) explained the Cultural Assessment of Risk for Suicide (CARS) is the only assessment that covers the cultural risks for suicide. The psychometrics for the Cultural Assessment of Risk for Suicide (CARS) results were reliable to a small extend for minorities and identified cultural-specific suicide risk factors, but consisted of 39 questions and was developed to be used in conjunction with other suicidal assessments (Chu, Floyd, & Diep, 2013). In an attempt to create a shortened version of CARS (CARS-S), it was still necessary to include 14-questions to maintain strong psychometric properties (Chu et al., 2018). It could be difficult to convince medical providers to include CARS or CARS-S in their procedures as it would require additional time to proctor multiple measurements (assessments/screeners).

Thus, the literature review shifted to focus on why communication was not aligning since it was not practical to suggest medical providers to proctor multiple measurements at a time. This author conducted research to ascertain the reasons behind different communication styles and the

negative outcomes from miscommunication. The academic domain of international business management addressed how cultural values and different philosophies influence the way people communicate. Thus, the literature review indicated that aligning communication between medical provider and patient requires an individualized, interpersonal, and culturally-sensitive approach.

Webinar methodology. The webinar was created in three different phases over a two-and-a-half-year period. The research question that directed this training effort led to the development of Phase One: a 60-minute video presentation for six key informants in the medical and mental health professions to view. An in-depth literature review for Phase One included international, national, and local statistics about completed suicides; how training may influence medical providers to screen for suicide; theories about suicide; cultural risk factors involved in suicide; classical risk factors involved in suicide; warning signs involved in suicide; patients who may not disclose suicidal ideation; screening tools to assess risk of dying by suicide; and screening techniques to assess risk of dying by suicide. Key informants offered feedback and evaluated the content at the end of the video presentation using a Google Form. Key informant feedback indicated that the theories and the cultural and interpersonal considerations about suicide were helpful to comprehending suicide. The key informants experienced an overall satisfaction with the training and supported localizing the training.

Results from Phase One guided the direction for Phase Two of the training effort. Phase Two consisted of a 90-minute in-person presentation for 1.5 continuing medical education credits (CME) presented on April 19, 2018, at the Symposium on Suicide hosted by the Fairbanks Wellness Coalition at the Westmark Hotel in Fairbanks, Alaska. This presentation was conducted by two UAF faculty members, Dr. Valerie Gifford and Dr. Heather Dahl, and three School of Education Counseling Program graduate students: Tomi Winters, Debbie Vance, and

Evelyn Griffin. Literature was reviewed for the development of "An Interpersonal Approach When Screening for Suicidality in Medical Settings: A Review of Best Practices" on topics including trauma-informed care, death studies, protective factors in the context of cultural diversity, the impact on medical providers when patients die by suicide, and cross-cultural communications from the field of international business management. Participants who attended the presentation at the Symposium on Suicide evaluated and offered feedback at the end of the presentation using an evaluation with Likert scale questions ($N = 10$). Nine out of ten participants who attended the training at the Symposium on Suicide reported that they thought they were sufficiently trained to screen people 15-17 years of age, sufficiently trained to screen people 18-24 years of age, knew how to screen adolescents, knew how to screen young adults, knew how to talk to patients at risk based on assessment/screening, and thought the presentation was relevant to their practice. Feedback from the participants indicated that short video vignettes providing an example of a suicide risk screening were helpful.

Results from Phase Two informed the development of Phase Three of the presentation: a second, revised version of the presentation. This in-person presentation lasted 60-minutes and was provided in-person for 1.0 CME for medical providers at Tanana Valley Clinic on December 3, 2018. This presentation was conducted by UAF faculty member Dr. Valerie Gifford, and four School of Education Counseling Program graduate students: Tomi Winters, Debbie Vance, Evelyn Griffin, and Kaitlin Rose Brown. Medical providers who attended the presentation at Tanana Valley Clinic evaluated it with Likert scale questions and offered feedback at the end of the presentation using an evaluation form ($N = 18$). More than 75% of medical providers who attended the TVC in-person training agreed or strongly agreed that the presentation added to their clinical knowledge base and was relevant to their practice, reported that they knew how to talk to patients based on assessment/screening, reported that they knew how to screen adolescent

patients, and thought they were sufficiently trained to screen patients between 15-17 years of age. Feedback from medical providers indicated a need to apply abstract theories about suicide in a concrete way to operationalize the theories. A final review of the literature after the completion of phase three supported the development of the Culturally-Grounded Interpersonal Model for Suicide Risk Assessment (C-GIMS).

Literature Review

The literature review for the webinar, "An Interpersonal Approach When Screening for Suicidality in Medical Settings: A Review of Best Practices," is composed of six sections. Knowing that best practice is to combine suicide risk measurements with clinical judgment, the first five sections of this literature review is to connect facets that comprise clinical judgment (Bouch & Marshall, 2005; Chung & Jelic, 2015). The first section contains the factors that influence medical providers to screen for suicide – knowing factors that influence aspects of screening for suicide. The second section is a comprehensive exploration of the C-SSRS, a suicide risk screener – knowing the advantages and disadvantages of a screening measurement. Next, the content of the webinar is reviewed – understanding a patient's experience of suicidal ideation – followed by an introduction and explanation of C-GIMS. C-GIMS will support choosing an individualized approach to screen for suicide risk. The fifth section of the review transitions to how medical providers approach a screening interview to assess for suicide risk. The approach will provide techniques toward understanding a patient's experience of suicidal ideation and lead to conceptualizing a patient's risk of dying by suicide. Aftercare for patients and medical providers conclude the literature review and connects with the first five sections as medical providers need to conceptualize a patient's risk of dying by suicide to plan appropriate aftercare options.

Factors that Influence Medical Providers to Screen for Risk of Dying by Suicide

When screening for suicide, medical providers may be influenced by the law, internalized societal values, and mainstream cultural viewpoints. Assumptions and hidden biases, based on a medical provider's philosophy, may impact how they approach and rate responses from a screening measurement. In this webinar, an approach means the following: the communication style (cultural/interpersonal/technical), the stance (a spectrum between open/curious to closed/defensive), and the questions (whether to reinterpret screening questions from a chosen screener). Therefore, each medical provider should consider their own personal philosophy as it can be a source of false positive and false negative results in screening measurements. Makridis (2016) wrote, "It ought to be clear to the informed student of the classical texts that Plato and Aristotle understand the business of philosophy to be reasoning and, indeed, correct reasoning" (p. 120). If a medical provider is looking for the "correct reasoning" for suicide risk based on their own personal philosophy, it can be difficult to understand a patient's experience of suicidal ideation. The law is an example of "correct reasoning" within society.

The law when screening for suicide risk. Luzon (2019) stated criminalization of euthanasia and PAS is a representation of the principle moral value of life and death. Emanuel, Onwuteaka-Philipsen, Urwin, and Cohen (2016) revealed that most developed countries have a high level of support for euthanasia and PAS, but there is less support among physicians. Emanuel and colleagues (2016) explained euthanasia and PAS were progressively becoming legalized, and that data did not indicate widespread abuse of euthanasia and PAS. As recently as February 2020, Germany's Federal Constitutional Court rejected a law that banned professionally assisted suicide as the law was determined unconstitutional (Maas, 2020). However, the *Professional Code for Physicians in Germany* clearly forbids physicians from performing euthanasia or PAS with the following code of conduct, "Physicians must support the

dying while preserving their dignity and respecting their wishes. They are forbidden to kill patients upon their request. They may not perform assisted suicide" [German Medical Assembly (GMA), 2018, p. 15].

As evidenced by this disagreement between Germany's Federal Constitutional Court and the German Medical Assembly, physician-assisted suicide (PAS) and euthanasia are controversial topics (Luzon, 2019). In other parts of Europe; such as the UK, assisted suicide and euthanasia are illegal (as cited in Luzon, 2019). Yet, in the Netherlands, Belgium, Luxembourg, Canada, and Colombia, euthanasia and PAS can be legally practiced (as cited in Luzon, 2019). In the USA, euthanasia is illegal in all 50 states (as cited in Luzon, 2019). PAS was legalized in Oregon, Washington, Colorado, District of Columbia, Vermont, and California (as cited in Luzon, 2019). Currently, in medical organizations in the USA, death by suicide is not an option, as the new campaign, "Zero Suicide," attests (Polychronis, 2018; ZeroSuicide, n.d.). The premise of "Zero Suicide" is that patient deaths by suicide are preventable in health systems (Polychronis, 2018; ZeroSuicide, n.d.).

And yet, in the United States of America (USA), there is a conflicting foundational value: autonomy. The mandate to stop a patient from dying by suicide, regardless of the loss of personal autonomy, can be difficult for a medical provider because individual freedom is firmly embedded in mainstream cultural values. Taking a person's civil liberties away by involuntary hospitalization is diametrically opposed to the principles upon which the USA was founded. Luzon (2019) revealed that the primary factor in support of decriminalization of euthanasia and PAS is the principle of autonomy. Personal autonomy is the basis of the argument to build a case to legalize suicide, even more so than the principle of death with dignity (Luzon, 2019).

Philosophies when screening for suicide risk. A medical provider's philosophy as well as core principles like personal autonomy, potentially encourages hidden biases. Further, a medical provider may be unable to accept a patient's experience of suicidal ideation. For example, when a medical provider has core values that are uncompromising, they may find it problematic to recognize, then challenge these biases. Yet, there are individuals with sharply defined values that are open to new perspectives. It is important to consider there are diverse philosophies in the world and within-group differences. In some Christian sects, the stigma of suicide and the prevalence of Christian beliefs against suicide is one example of within-group differences (Chu, Goldblum, Floyd, & Bongar, 2010; Durkheim, 1897/1951). Christianity was influenced by the different schools of Greek philosophy (Aszyk & Zabytivska, 2004). Within the Christian faith, generally-speaking, martyrdom was accepted as Jesus himself was a martyr. However, early Christian philosophers believed in an "undisputable, absolute forbiddance of suicide" (Aszyk & Zabytivska, 2004), and Gnostic Christians believed that martyrdom was unneeded and equivalent to suicide (Kelley, 2006).

In some cultures, the circumstances of death and the reason for dying determine whether suicide is acceptable (Im, Park, & Ratcliff, 2018; Leong, Leach, Yeh, & Chou, 2007; Leong, Kalibatseva, & Perera, 2015; Lo, 2010; Park, 2013). Lo (2010) elucidated that according to the Chinese philosopher Confucius, having a meaningful and honorable death is more important than continuing to live for the sake of living. Conversely, dying by suicide for oneself is considered self-destructive and a person was pitied for doing so (Dongno, 1990; Leong et al., 2007, 2015; Lo, 2010; Park, 2013). Dying by suicide for oneself is viewed as immoral and shameful because it creates doubt about how children were raised in a family (Im et al., 2018; Lo, 2010; Park, 2013). Cultural philosophy about death by suicide may be stronger than religious philosophy is some locations (Leong et al., 2007). For example, Leong and colleagues (2007) asserted

Buddhist philosophy is influenced by the individual cultures where Buddhism is practiced. Leong and colleagues (2007) wrote that in Buddhist teachings, death is considered inevitable and one must prepare themselves for death; therefore, if a person dies by suicide they will not have time to prepare for the next realm.

Philosophical differences and screening for suicide risk. Not just in religious settings, philosophy influences distinct within-group difference. For example, American farmers represent a within-group difference in mainstream culture. Historically, rates of death by suicide for farmers have been five times higher than the national average. Reasons for the high suicide rate include net farm income responsibilities, social isolation, pesticide-induced concerns, and stigma related to mental health problems (Fitchette, 2018). Recently, Peterson and colleagues (2020) reported suicide rates were significantly higher in the agricultural industry group and workers in the field continue to experience higher suicide rates than other professions.

Another example of within-group differences in the USA are patients who die by suicide after a difficult health diagnosis, such as cancer. Death by suicide is often tied to a patient's belief they are or will be a burden to their family (Cooke, Gotto, Mayorga, Grant, & Lynn, 2013; Garlow & Murphy-Ende, 2018). A retrospective study was conducted using US representative data from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program between 1973 and 2014 (Zaorsky et al., 2019). Out of 8,651,569 patients diagnosed with invasive cancer, 13,311 died by suicide at 28.58/100,000 people. This rate is more than double the national average suicide rate of 14.0/100,000 people (AFSP, 2020). The highest risk of suicide among people diagnosed with cancer were people diagnosed with lung, testes, head and neck, bladder, and Hodgkin Lymphoma cancer.

One last example of a distinct within-group difference that influences a person's risk of dying by suicide is the characteristic, traditional masculinity. Vlessides (2020) indicated that men

who identified with a higher level of traditional masculinity were two and a half times more likely to die by suicide than men who did not hold the same beliefs. Traditional masculinity was defined as including characteristics of competitiveness, restriction of emotions, and aggression (Vlessides, 2020). On the other hand, within-group differences may not be the main factor because there are many variables involved when a person experiences suicidal ideation.

People at risk of dying by suicide may be at such a crisis point that cognitive functioning is limited; this loss of cognitive functioning is why a medical provider's clinical judgment during a suicide assessment is standard practice (Bouch & Marshall, 2005; Chung & Jeglic, 2015). People who are experiencing intoxication; mania; severe, persistent mental illness; psychosis; and side-effects of medication may need a medical provider's support and protection if their own mind becomes compromised (as cited in Dryden-Edwards & Shiel, 2016). A person may be genetically predisposed to suicidal behavior or may misattribute suicidal ideation to an existential crisis instead of the symptoms of major depressive disorder (Shermer, 2018). The assessment for risk of dying by suicide by a medical provider is an important step when a person misattributes symptoms of major depressive disorder to something else.

Philosophical influences and the approach when screening for suicide risk. When medical providers are assessing for suicide risk with patients who are in crisis, philosophy may influence their screening approach: the communication style (cultural/interpersonal/technical), the stance (a spectrum between open/curious to closed/defensive), and the questions (whether to reinterpret screening questions from a chosen screener). For example, if a medical provider believes suicide is wrong and they are unable to consider another perspective, then a communication style like exploring, empathizing, understanding, and accepting a patient's experience of suicidal ideation will be nearly impossible. A stance of curiosity is an influential factor when screening for suicide. Medical providers who lack the curiosity may not ask open-

ended questions. A patient may not be aware of experiencing suicidal intent. It may not be until the patient has time to reflect upon death by suicide that the patient realizes they are suffering from suicidal ideation (Shea, 2009; Shea, 2012). Medical providers are authority figures in our society and their approach can offer a safe space to talk about a highly stigmatized topic: suicide.

The approach when screening for suicide is important because the main reason patients did not disclose suicidal ideation was the fear medical providers would involuntarily hospitalize them (Hom, Stanley, Podlogar, & Joiner Jr., 2017). Medical providers wanted to be sure their patients were not at imminent risk of dying by suicide. Patients wanted support, empathy, and understanding after disclosing suicidal ideation. The outcome of disclosing suicidal ideation was that medical providers asked more questions 87.5% of the time (Hom et al., 2017). In an effort to avoid additional questioning by medical practitioners, patients may avoid disclosure of suicidal ideation. Several other reasons a patient may not share suicidal thoughts are fearing loss of respect, loss of occupation, experience of shame, or confiscation of firearms (Shea, 2012).

Further, people who identify as an ethnic minority may need a different approach when assessing for suicide risk (Chu et al., 2010; Morrison & Downey, 2000). "Hidden ideators" are patients who identified with an ethnic minority group and were less likely to self-disclose feelings of suicidal ideation unless directly evaluated by clinicians (Morrison & Downey, 2000; Pokorny, 1992). Medical providers who use a screener that relies on self-reporting, can misidentify people who are "hidden ideators" as being at low of risk of dying by suicide when they are actually at high risk of dying by suicide. A checklist to identify people who are "hidden ideators" has not been devised. However, medical providers can gain knowledge of cultural differences as it is an important consideration when screening for suicide risk (Chu et al., 2010, 2013, 2017, 2018, 2019).

Self-awareness and screening for suicide risk. Increasing one's knowledge of diverse cultures and self-awareness influence screening for suicide. Health care providers who have implicit biases toward people of color significantly impacted patient health outcomes (Agency for Healthcare Research & Quality, 2019; Hall et al., 2015; Smedley, Stith, & Nelson, 2003).

A review of patient-provider communication and healthcare disparities for people who identify as an ethnic minority revealed that clinicians who were not culturally competent lacked skills to communicate and facilitate collaborative treatment plans (Perez-Stable & El-Toukhy, 2018). When health providers are not aware of their personal biases or how their worldviews may impact patient care, patients may feel misunderstood and invalidated (Gonzalez et al., 2018; Perez-Stable & El-Toukhy, 2018). Successful patient-client communication is a way of decreasing healthcare inequality (Perez-Stable & El-Toukhy, 2018). When medical providers perceived their biases, acknowledged their biases, and adjusted their behaviors after an incident with patients, the outcome of the interaction could still be positive (Gonzalez et al., 2018).

With self-awareness, health providers can question if their biases influence their attitudes and behavior. For example, Nankivell, Platania-Phung, Happell, and Scott (2013) studied the perspectives of nurses with regard to patients diagnosed with serious mental illness, and they found two main themes as causes of poor access to physical health care: (a) clinical barriers to primary care and (b) attitudinal barriers. In a study conducted in Norway, researchers determined general practice, psychiatry, and internal medicine providers had the lowest empathy and lowest commitment to patients who misuse substances (narcotics, opiates, tranquilizers, and alcohol), while having more irritation toward patients who misused drugs and alcohol (Grimholt, Haavet, Jacobsen, Sandvik, & Ekeberg, 2014). In contrast, the three groups of physicians (general practice, psychiatry, and internal medicine) had positive attitudes toward patients with suicidal ideation. They were empathetic and wanted to help their patients. However, Tsai, Lin, Chang,

Yu, and Chou (2011) noted further research should be conducted regarding the impact of medical providers with negative attitudes toward patients who attempt to die by suicide. The authors acknowledged medical providers may not comprehend suicide as a way to end misery, and without self-awareness may express their beliefs with a lack of empathy toward patients who are suffering from suicidal ideation.

Training and screening for suicide risk. Training can increase quality care from medical providers (Burka, Van Cleve, Shafer, & Barkin, 2014; Hooper et al., 2012; Tsai et al., 2011). In Taiwan (Tsai et al., 2011), after completing a training program, nurses were more likely to screen for suicidality when indirect warning signs were present. Indirect suicide warning signs were: isolation, poor appetite, increased appetite, poor sleep, and loss of interest in hobbies. Burka and colleagues (2014) conducted a study with pediatric primary care providers who were asked to care for children with mental health disorders. They found that inadequate training served as a primary barrier to the providers' ability to deliver medical care. In a study conducted by Grimholt and colleagues (2014) in Norway, a total of 43% of physicians received education or training for treating suicidal patients within the past five years. Psychiatrists had the most training for treating patients with suicidal ideation at a rate of 76%, followed by 39% of general practitioners, and 15% of internists. Competence levels were aligned with physician areas of specialty, with the highest level of competence being the psychiatric group.

Primary care physicians do not inquire about suicidality consistently (Feldman et al., 2007; Hooper et al., 2012). For example, Hooper and colleagues (2012) reported that out of 404 primary care physicians, 36% inquired about suicide at the time when a patient presented with major depression at a level of moderate severity. The primary care physicians were significantly more likely to inquire about suicide risk if there was a comorbid medical illness with psychological distress. The researchers suggested that physicians may not believe that patients

with moderate depressive symptoms were at a high risk for dying by suicide (Hooper et al., 2012). Additionally, Hooper et al. (2012) found younger physicians were more likely to assess for risk of suicide. Thus, physician age was a significant finding. The higher the age of the physician, the less likely the physician would be to perform a risk assessment for suicide. The researchers suggested that experienced physicians should continue medical education for suicide risk assessment.

New findings in the literature. The suggestion by Hooper and colleagues (2012) to continue medical education specific to suicidal ideation may be due to new research in the field of suicidality. For example, cultural risk factors such as cultural sanctions, idioms of distress, minority stress, and social discord, was published in 2010 (Chu et al., 2010). The C-SSRS was developed in 2007 (The Columbia Lighthouse Project, 2016). The C-SSRS did not include cultural risk factors since they were not introduced in the literature until 2010. Cultural sanctions are the beliefs held by a specific cultural group regarding the acceptability of suicide (Chu et al., 2010). Idioms of distress are the ways people express suicidal ideation. Minority stress relates to the experiences of discrimination a person of color or a person who identifies with a sexual minority group experiences (Chu et al., 2010). Social discord is a cultural risk factor for a member who identifies with a minority group when a level of disharmony exists between the person and their family or cultural group (Chu et al., 2010).

The two types of risk factors identified in the literature are classified between classic and cultural (Chu et al., 2010, 2013, , 2017, 2018, 2019). Chu and colleagues (2019) conducted a study comparing classical risk factors with cultural risk factors to predict future suicide attempts. After measuring the variance in the accuracy of classical risk factors and cultural risk factors for predicting suicide attempts, the researchers determined that cultural risk factors improved the total prediction level of suicide attempts by an additional 8%. In this study, the classical risk factors studied were hopelessness,

depression, and lack of reasons for living (Chu et al., 2019). Cultural risk factors studied were cultural sanctions about suicide, minority stress, and social discord (Chu et al., 2019).

In summary, society is informed by a variety of philosophical underpinnings in regards to suicide. Diverse philosophical, cultural, and legal perspectives require that medical providers be able to discern how individuals present with, think about, and express thoughts of suicide. Providers may find it challenging to assess for risk when one method does not work for every patient, each and every time. Patients from diverse ethnic backgrounds may respond accurately to direct questions from a scientifically derived diagnostic model assessing for suicide, or they may respond accurately to a provider who engages with them using empathic curiosity about suicide. To complicate matters even more, providers must be attuned to within-group differences in various cultural groups, meaning that not every member of a specified group is going to respond accurately to the same approach to risk assessment. Provider attitudes and beliefs about suicide and patients who experience suicidal ideation influence their effectiveness when screening and assessing for risk.

Researchers in the field of suicidology recommend that providers be trained to screen for suicide in order to improve patient healthcare outcomes. This author identified a gap in the literature in that although continuing education was recommended, the content of such training was missing. Based on the literature reviewed here, it is apparent that effective and accurate screening for a patient's risk of suicide is influenced by the provider's cultural competency, their own worldview, and their perceptions of the patient's distress level, symptom presentation, and comorbidity with other illnesses. To fill this gap, effective training warrants a focus on improving clinical judgment by enhancing a provider's perspective-taking, cultural attunement, and integration of cutting-edge contributions from the field of suicidology.

Screening and Assessment in the Field of Suicidality

The C-SSRS is a cutting-edge instrument, a screener that was developed to assess risk of suicide. Screening measurements were one of the most important issues medical providers in the

Fairbanks North Star Borough requested in a suicide prevention training (Goldstream Group Incorporated, 2017). Unfortunately, there is no assessment tool, assessment technique, list of risk factors, or set of warning signs that encompasses every aspect of suicide (Franklin et al., 2017; Ghasemi et al., 2015; Gidden et al., 2014; Tucker, Crowley, Davidson, & Gutierrez, 2015). One of the few things that is definitely known about suicide is the difficulty of detecting suicide risk, and not enough research is being conducted in medical emergency departments to improve suicide risk assessments (Bowers et al., 2018).

Ghasemi and colleagues (2015) conveyed that the diverse nature of experience of suicidal ideation and risk factors among patient populations is a limitation of suicide risk assessments. Researchers have yet to prove that risk factors predict when a person dies by suicide (Franklin et al., 2017; Sommers-Flanigan & Shaw; Tucker et al., 2015). However, it is important to know that risk factors are beneficial for clinical judgment. Risk factors support efforts to contextualize patients (Sommers-Flannigan & Shaw, 2017). Currently, mental health professionals are combining risk measurements to maximize variables for a comprehensive suicide risk assessment. After these measures are completed, clinical judgment is included in determining a patient's risk of dying by suicide (Chung & Jeglic, 2015).

VandenBos (2007) defined clinical judgment in the field of psychology as an analysis, prediction, or evaluation of presenting symptoms in a patient with a disease, disorder, impairment, or dysfunction. It includes a degree of clinical involvement and knowledge from the health professional. In the field of medicine, clinical judgment is the thought process that leads a provider to make a conclusion based on subject and objective patient data and is developed through practice, knowledge, experience, and critical analysis (Kienle & Kienle, 2011). Clinical judgment covers medical areas like the diagnosis process, therapeutic process, patient-provider communication, and making decisions. For this webinar, clinical judgment includes the

following facets: knowing the factors that influence aspects of screening for suicide, knowing the advantages and disadvantages of a screening measurement, understanding a patient's experience of suicidal ideation, choosing an individualized approach to screening for suicide, and conceptualizing the level of risk for a patient's death by suicide. As the literature review moves through the upcoming sections, the facets of clinical judgment will be addressed. In the previous part of the review, factors that influence aspects of screening for suicide were covered. This next part of the review is an appraisal of the C-SSRS to identify the advantages and disadvantages of this screening tool.

The Columbia-Suicide Severity Rating Scale (C-SSRS). Gangwisch (2010) recommended the use of C-SSRS for primary care physicians and emergency physicians, stating that the C-SSRS is an assessment that covers suicidal behaviors, as well as the severity and intensity of suicidal ideation. The C-SSRS was declared by the Food and Drug Administration as the standard for measuring suicidal ideation since 2012 (The Columbia Lighthouse Project, 2016). The C-SSRS is used to assess for the severity and intensity of ideation, suicidal behavior, and the lethality of actual suicide attempts while incorporating an in-person interviewing approach. It has standardized questions and is specific in language. It is ideal for primary care physicians who may have patients for many years, providing a baseline for safety monitoring and a flexible time frame to assess for suicide risk (Gangwisch, 2010). There are many versions of the C-SSRS, including ones for children, adolescents, individuals with cognitive disabilities, and people who speak Spanish as their first language (The Columbia Lighthouse Project, 2016).

The C-SSRS foundation is based on an ideation-to-action theory (Klonsky, Saffer, & Bryan, 2018). The C-SSRS incorporated the first ideation-to-action theory of its kind to a screening measurement: Joiner's (2005) interpersonal theory of suicide. The premise for the ideation-to-action theory is that thoughts are separated from the behavior required to die by

suicide. Additional information on Joiner's interpersonal theory of suicide is included further in this literature review. The C-SSRS is validated by research and is an evidence-based measure for risk of suicide (The Columbia Lighthouse Project, 2016; Posner et al., 2011). Researchers on the scale's predictive validity confirms that C-SSRS is effective at identifying people at risk of dying by suicide (The Columbia Lighthouse Project, 2016). Posner et al. (2011) conducted three studies to assess for the psychometric properties of the C-SSRS. The ratings significantly predicted suicide attempts: actual, interrupted, and aborted. The behavior subscale demonstrated high levels of sensitivity and specificity relative to behavior and changes over time. The C-SSRS identified ideation types (passive and active), level of intent, and plan.

On the other hand, Giddens et al. (2014) criticized the C-SSRS for the fact that some of its questions invite answers that may be potentially ambiguous. Although the C-SSRS questions are standardized, the way a patient answers a question is not, thus lowering inter-rater reliability (the rater is the person proctoring the screening). Raters, using the C-SSRS rating scale, may misidentify a person experiencing suicidal ideation and classify them at low risk when they are actually at high risk of death by suicide (false-negative). The reason a false-negative result is a concern is that the main questions rely on an affirmative answer before moving on to the next question: (a) wish to be dead, (b) non-specific active suicidal ideation, (c) active suicidal ideation with any methods without intent, (d) active suicidal ideation with some intent to act without a plan, and (e) active suicidal ideation with plan and intent (The Columbia Lighthouse Project, 2016). Additional questions rate the intensity, suicidal behavior, how an attempt was aborted, and lethality based on an affirmative answer from the preceding question. If the rater misinterprets a response during the screening, questions are left unasked. Based on the answers, raters do not follow up with additional questions about a patient's method, intent, or plan because the questions are sequential.

False-negatives using the C-SSRS could be related to the communication styles of individuals who identify as an ethnic minority compared to people who identify as White-European. Raters may ask the questions as they are written on the C-SSRS, in a direct manner. If a rater asks questions in a way that is perceived by the patient as being mechanical, or lacking in interpersonal connection or empathy, the patient may not appreciate or respond productively to the questions. Patients may not be aware they are experiencing suicidal ideation and deny that they wish to be dead, thus terminating the screening without exploring thoughts that classify as suicidal ideation. In some cultures, it is taboo to use the word "suicide." It may be that a patient will use the word "disturbing thoughts" to replace "suicide." It is important to ask patients to define words because it may be in that moment when they realize they are experiencing suicidal ideation.

In summary, current practice in the field of suicidality is to combine measurements with clinical judgment. A facet of clinical judgment is knowing the advantages and disadvantages of a screening measurement. The C-SSRS is an evidence-based screening tool that uses a theory of suicide as the premise to assess suicide risk. However, the C-SSRS inter-rater reliability is a concern. The limitations of the C-SSRS stem from the non-standardized way a patient answers the screening questions and the way a rater interprets patient answers. Patients communicate differently, and a single approach to screening for suicide using the C-SSRS will not be effective for every patient. Fortunately, the C-SSRS is a flexible screener that allows for an individualized approach. A rater (person proctoring the screening) needs to consider the importance of perspective-taking and cultural attunement—both of which influence understanding a patient's experience of suicidal ideation and ultimately, the screening approach chosen by the medical provider. The following section reviews literature in the field of suicidality to enhance clinical judgment: understanding a patient's experience of suicidal ideation.

Research in the Field of Suicidality

Sommers-Flanagan and Shaw (2017) stated clinical judgment is an important process to suicide risk assessments. Understanding a patient's experience of suicidal ideation is another facet of clinical judgment. The C-SSRS, based on an ideation-to-action theory of suicide, is the screening measurement chosen for the training. The C-SSRS appears simple, but it is not easy to screen for suicide risk. In a meta-analysis of the past 50-years of research in suicidality, Franklin and colleagues (2017) explained that suicide risk factors did not predict when a person would die by suicide, and that some of the theories on suicide were probably only partially accurate or even largely inaccurate.

Based on research indicating that some theories and some risk factors for specific populations are accurate, a combination of theories for diverse patients and situations may be an effective approach. Research in the field of suicidality informed the content for the webinar, "An Interpersonal Approach When Screening for Suicidality in Medical Settings: A Review of Best Practices." The components from the field of suicidality includes Durkheim's (1897/1951) sociological theory of suicide, a cultural model of suicide (Chu et al., 2010), Joiner's interpersonal theory of suicide (Joiner, 2005), classical risk factors, cultural risk factors (Chu et al., 2010), warning signs, and protective factors.

Durkheim's sociological theory of suicide. Durkheim (1897/1951) classified suicide in a societal context using the two factors of social integration (community solidarity) and social regulation (norms that limit desires). The imbalance of these two factors in society defined four different types of suicide. The first type of suicide was altruistic suicide. It was caused by very high levels of social integration (community solidarity) and very low levels of social regulation (norms that limit desires) in society. When individuality was fully absorbed by a group, social integration became overdeveloped at the expense of social regulation. Durkheim (1897/1951, p. 219) noted society could "lead [a person] to destroy himself" because the group becomes more

valuable than the individual. Altruistic suicide may be considered acceptable by some cultures depending on the reason for dying by suicide. One example is the kamikaze pilots during World War II, who used their planes to die by suicide. This way of dying was considered honorable as they were protecting their country (Wendler, Matthews, & Morelli, 2012). A local example are Alaska Native communities where, historically, Elders died by suicide when they believed the burden of caring for them was not in the best interest of the village (Wendler, Matthews, & Morelli, 2012).

Another type of suicide identified was "egoistic" suicide (Clegg, Cunha, & Rego, 2016; Pope, 1976). Egoistic suicide occurred when social integration levels (community solidarity) were too low and social regulation levels (norms that limit desires) were too high (Pope, 1976). Living life for oneself caused feelings of detachment, uselessness, and aimlessness (Durkheim, 1897/1951). The bond to life was weakened as apathy and self-complacency led a person to believe life was not worth the burden of being lived at all; so when a difficult circumstance occurred, the person was not capable of resilience (Durkheim, 1897/1951). Egoistic suicide is stigmatized more than other types of suicide in some Confucian-based collectivistic cultures (Leong et al., 2007, 2015; Lo, 2010; Park, 2013). Im and colleagues (2018) illustrated how stigma surrounding suicide may be influencing suicide rates in South Korea with the suicide of Lee Yoon-hyung, 26, the heiress and youngest daughter of the Samsung company chairman and one of the richest men in South Korea (Baker, 2005). A Samsung public relations representative initially announced she died in a car accident, but she died by suicide (Baker, 2005).

The last two types of suicide Durkheim (1897/1951) identified were fatalistic and anomic. The meaning of fatalistic and anomic suicide, interpreted through historical and cultural aspects, potentially influences societal definitions of suicide. Fatalistic suicide occurred when society, with very high levels of both social integration (community solidarity) and regulation

(norms that limit desires) constrained people to such an extreme degree that it led individuals to die by suicide. An example of fatalistic suicide are people who live in countries with an authoritarian government system. A specific historical event of fatalistic suicide is the death of Tarek el-Tayeb Mohamed Bouazizi, a fruit vendor in Tunisia during the Ben Ali regime, who died by self-immolation when government officials confiscated his scales he used to conduct business at an outdoor market. This death by suicide was the catalyst for the Arab Spring Revolution in December 2010 (Lageman, 2016; Wolf, 2018). Although suicide is forbidden in the practice of Islam, one of Bouazizi's cousins stated, "What he did was not right…but I understand why he did it" (Lageman, 2016, para. 8).

Durkheim's anomic suicide was the result of very low levels of social integration (community solidarity) and social regulation (norms that limit desires). This occurred when norms were not clearly defined and people lacked social integration. The definitions of social norms were either ambiguous or counter to the way society used to function. Events that change history, society, and culture influence anomic suicide because part of anomie is a lack of societal norms within a population. For example, the Korean War was a historical event that changed South Korea from a traditional economy to a free-market economy. Familism, the economy, the education system, and gender roles shifted (Kim, 1990; Park, 2013; Park, Im, & Ratcliff, 2014). Societal changes led to cultural ambivalence (Park, 2013), which influenced the society toward anomie. Kim (1990) revealed modern South Korean culture, a traditionally Confucian and collectivist society, changed their family structure so that extended family and villages no longer relieved pressure from immediate family members by sharing successes and failures. Kim (1990) characterized Korean modern familism as amoral, as the pursuit for individual interests in modern times destroy cooperative mechanisms from traditional times.

Another example of the creation of an anomic environment is the loss of a community when workplace cultures change due to layoffs or consolidations in departments within a company (Clegg et

al., 2016). Clegg and colleagues (2016) suggested that the loss of solidarity and the lack of norms create an anomic working environment. The solidarity of a community, where roles and expectations were once secured and understood, change when companies restructure. A principle once valued and rewarded in an organization may no longer be stable and easily defined. The low level of social integration and social regulation from the loss of co-workers and managers are caused by the change in norms and values within the work culture.

Interpersonal theory of suicide. Joiner's (2005) interpersonal theory of suicide is guided by the premise that a person's suicidal ideation is separate from their ability to die by suicide (Joiner, 2005; Van Orden et al., 2010). Joiner's theory is based on three constructs: perceived burdensomeness, thwarted belongingness, and the capability to die by suicide. Perceived burdensomeness is when death is worth more than living because a patient's perception is that they are a burden to others. Thwarted belongingness is when one feels alone and lacks a reciprocated caring relationship (Joiner, 2005). Capability to die by suicide is defined by the behaviors of increased pain tolerance and habituation of death, when the mind begins to endure the acts of dying by suicide (Joiner, 2005).

If one of these factors (thwarted belongingness or perceived burdensomeness) is combined with a feeling of hopelessness that the situation will not change, this combination will lead to passive suicidal ideation. Van Orden (2015) took a more conservative approach, suggesting even one factor with a feeling of hopelessness could lead to active suicidal ideation. Meanwhile, Joiner (2005) delineated how thwarted belongingness combined with identifying oneself as a burden (and further, believing that both situations are unchangeable and hopeless) led to active suicidal ideation. With a lowered fear of death comes the transition to suicidal intent, and an increased tolerance to physical pain evolves into suicidal behavior (Joiner, 2005).

Joiner's belief that a lowered fear of dying leads to suicidal intent (Joiner, 2005). Importantly, acquiring the capability to die by suicide requires a level of pain tolerance because the fear of death and pain must be overcome first (Joiner, 2005). The ability to die by suicide is created when a habit of taking lethal risks and tolerating increased levels of pain become normal. The fear of dying by suicide is reduced when habituation forms from previous attempts (Joiner, 2005). With habituation, people who have active suicidal ideation may reinforce the act of suicide because, when lowering their fear of death, they may be increasing the positive effects: pain relief, feelings of competence, and the exhilaration of attempting suicide (Joiner, 2005).

When the three constructs (perceived burdensomeness, thwarted belongingness, and the capability to die by suicide) interconnect, lethal and near-lethal attempts will occur. An elevated physical pain tolerance will transition into suicidal behavior, and suicide attempts will take place (Joiner, 2005). Even physicians habituate to observing pain; they have a capability for suicide higher than the general population because of the nature of their work (Joiner, 2005, p. 73). Physicians' habituation to pain does not mean physicians will die by suicide; rather, it means their capability to die by suicide is higher than the average individual's. Joiner (2005) described people who are employed as race car drivers as another example. Their occupation demands risk-taking and daring against death, but compared to other professions, they do not attempt suicide more frequently (Joiner, 2005).

Klonsky and colleagues (2018) explained the C-SSRS is based on an ideation-to-action theory, and Joiner's interpersonal theory of suicide is the first of its kind. Researchers listed substantial evidence supporting the interpersonal theory of suicide (Klonsky et al., 2018; Sommers-Flanagan & Shaw, 2017). Joiner's theory was created with an effort to combine previous research about risk and protective factors. The timeline for the classical risk factors, Joiner's interpersonal theory of suicide, and the creation of the C-SSRS occurred prior to 2007.

Cultural model of suicide. In contrast, Chu et al. (2010) developed the cultural model of suicide from a 20-year literary analysis of US national data after 2007. First, the researchers determined four culturally-specific risk factors using a literary analysis from 1991-2011 studies of people who identified as part of Asian American, African American, Latino/Latina American, and LGBTQ+ minority groups. The researchers gathered four suicide risk factors that were responsible for 95% of the culturally specific risk information in the literary analysis: minority stress, social discord, cultural sanctions, and idioms of distress. Minority stress includes harassment, discrimination, internalized stereotypes, acculturative stress, and living in a society with institutionalized racism (Chu et al., 2010). Social discord includes conflict, alienation, lack of integration, and interpersonal conflict with people who identify as an ethnic and/or sexual minority. Cultural sanctions is whether suicide is considered an acceptable act. Idioms of distress are the expressions of suicidal ideation. Additional information about cultural risk factors is included later in this literature review.

The authors explained that risk factors are part of the framework of the cultural model of suicide. Life stressors are personal or social stressors and include minority stress, social discord, and cultural sanctions. Life stressors do not operate in seclusion, because life events have different meanings; they are influenced by culture. Cultural factors influence whether suicide is a viable solution to life stressors. Cultural sanctions of suicide determine whether one chooses suicide, because the suicide attempt is based on whether one's threshold for distress is exceeded. The threshold to attempt suicide is based on the cultural view that suicide is acceptable and whether a life event is affectively tolerable to an individual. The threshold to attempt suicide may be more easily surpassed when society does not view suicide as immoral (Chu et al., 2010).

How these four factors influence suicide risk depends on within-group differences, acculturation levels, and the intersectionality of an individual's multiple identities. For example,

losing one's job may be shameful in some cultures (unacceptable life stressor) whereas some other cultures may see losing a job as an opening for a new career (acceptable life stressor). Losing a job may induce feelings of shame for a person who identifies with a minority group while for other people it may be seen as a common life experience. If a life event is unacceptable, person may consider suicide as a solution if there are no cultural sanctions against suicide. If suicide is not acceptable in their culture, the person is more likely to tolerate the feelings of shame from losing a job. Chu and colleagues (2010) demonstrate how culture influences a patient's risk of dying by suicide with the cultural risk factors and the model of suicide. Meanwhile, risk factors improve understanding a patient's experience of suicidal ideation (Sommers-Flanigan & Shaw, 2017).

Classical risk factors. The following is a list of classical risk factors: depression, alcohol/substance use disorders, impulsivity, chronic pain, serious health illnesses, anxiety, family adversity, previous suicide attempts, family history of suicide, recent discharge from hospital or treatment center, and access to a firearm (American Association of Suicidology, 2020; AFSP, 2020; Bouch & Marshall, 2005; Cooke et al., 2013). In a review of 12 peer-reviewed articles measuring parental bonding in patients with suicidal ideation or suicidal behavior, researchers asserted that "decreased parental care ratings, and more specifically reported affectionless control was significantly associated with higher levels of suicidality" (Goschin, Briggs, Blanco-Lutzen, Cohen, & Galynker, 2013, p. 2). Affectionless control is low parental care and high parental overprotection. Affectionless control was a significant suicide risk factor for young adults and adolescents (Goschin et al., 2013).

Cultural risk factors. There are four cultural risk factors: social discord, idioms of distress, cultural sanctions, and minority stress (Chu et al., 2010). Social discord is defined as a lack of integration, interpersonal conflict, and alienation from one's community, friends, and/or

family. A second cultural risk factor, idiom of distress, refers to how a patient exhibits distress. Chu et al. (2010) found that people who identify with an ethnic and/or sexual minority group experience three types of idiom of distress: expression of suicide, expression of suicide symptoms, and the method of attempting suicide. The premise for the risk factor, idiom of distress, is that people who do not identify with mainstream dominant culture express suicide differently from those who do identify with mainstream dominant culture.

In addition, geographical location may constitute an idiom of distress. For example, the idiom of suicide (a method of attempting suicide) may be different based on geographical location. A local illustration is a teenager who presents to Fairbanks Memorial Hospital emergency room with a broken leg from a snow machine accident. The injury may be more complicated than it would seem. This teenager's injury could be related to an attempt to end their life, and not necessarily be a routine snow machine accident. Another example of a geographical idiom of distress is an Alaskan who drives ten miles more than the speed limit during an Alaskan winter compared to a Californian who drives ten miles more than the speed limit. Roads in Alaska are slick with ice and there is the danger of quickly freezing to death at -40 degrees.

A third cultural risk factor is cultural sanctions. Cultural sanctions refer to suicide as an acceptable or unacceptable solution in a particular community. One should consider not just people who identify with ethnic minority groups and sexual minority groups, but religious groups as well. For example, church leaders who are at risk of dying by suicide may be ashamed and think it reflects poorly on their faith to seek help for depression. There are within-group differences to consider as well. Even between people who identify within Christian sects: Catholicism and Protestantism, there are differences in suicide rates (Durkheim, 1897/1951). Durkheim noted there are less deaths by suicide among Catholics than Protestants. The difference may be there is a stronger degree of stigma of dying by suicide in Catholicism

compared to Protestantism. Durkheim made note that Catholic practices center around family and community while Protestant practices center around autonomy and independence.

The last cultural risk factor is minority stress. Minority stress includes discrimination, harassment, and racism. A less known minority stress is acculturation, which may impact people who identify as immigrant, first-born generation, second-born generation, or bicultural/multiheritage. There are numerous incongruent cultural values found among people who identify with ethnic minority groups that are in conflict with mainstream dominant culture (Chu et al., 2010; Sue & Sue, 2013). For example, there are two dimensions in Asian American parent-child conflicts that arise from differing cultural values: respecting elders by conforming to family norms, and the higher level of expectation for Asian American students to succeed academically and occupationally (Tsai-Chae & Nagata, 2008; Wong, Wang, Li & Liu, 2017). The dissonance between the cultural values of family norms and education/career issues may lead to social discord if there is family conflict over the disagreement.

Warning signs. Warning signs are unique to the individual compared to suicidal risk factors, which is general. Risk factors are frequently unchangeable, long-standing, and are derived from research (Van Orden et al., 2008; Miller, 2011, 2015). Warning signs are dynamic and are derived from clinical practice (Van Orden et al., 2008; Miller, 2011, 2015). When a situational crisis occurs, suicide warnings may increase. A situational crisis can trigger suicidal behavior (Miller, 2011, 2015). The following warning signs and symptoms require immediate attention: threatening suicide; looking for ways to die by suicide; hopelessness, rage or anger; feeling trapped; an increase in alcohol/drug use; social withdrawal; anxiety; sleep problems; mood changes; and lack of reasons for living are all significant warning signs (The American Association of Suicidology, 2020; AFSP, 2020; Gangwisch, 2010). Like idioms of distress,

warning signs may be culturally-influenced, being dynamic and based on the crisis situation (Miller 2011, 2015).

Protective factors. Protective factors are considered one part of patient conceptualization of dying by suicide, as long as providers are aware that protective factors do not discount risk factors (Joiner et al., 2007). Protective factors may be culturally-influenced. In a study about rural Alaskan community protective factors, 25 students who identify as Alaska Native who migrated to Fairbanks, Alaska stated practicing traditional ways and subsistence activities established relationships in their community that promoted an active lifestyle (DeCou, Skewes, & López, 2013). Traditional practices were perceived to create the context for social support and relationships to promote healthy living (DeCou et al., 2013).

Beaudoin et al. (2018) wrote about the different protective factors for people who identify as Inuit in Nunavut, Canada. Three equal groups of 30 people: people who have not attempted suicide, people who have attempted suicide, and people who died by suicide (N=90) were studied to gain information about protective factors among the Inuit people. One finding from this study was the group of people without suicide attempts had more protective factors throughout their lifespan in environmental, social, and individual areas than the group of people who died by suicide and the group of people who attempted suicide. There were more protective factors within the environmental area (stability, positive change, and achievements), social area (family, intimate, and friendly relationships), and individual area (personal resources and personal behavior) for people who have not attempted suicide. The researchers stated compared to the social and individual protective factors, environmental protective factors had the greatest difference between the three groups and it was significantly more present among the people in the group with no attempt of suicide compared to the people in the groups with an attempt of suicide and death by suicide (Beaudoin et al., 2018).

In summary, research in the field of suicidality aims to improve clinical judgment by understanding a patient's experience of suicidal ideation. A review of the research can improve clinical judgment by understanding the influence of society and culture on suicide include Durkheim's (1897/1951) sociological theory of suicide, Joiner's (2005) interpersonal model of suicide, and Chu and colleague's (2010) cultural model of suicide. Classical risk factors, cultural risk factors, warning signs, and protective factors amplify the understanding of a patient's experience of suicidal ideation. The cutting-edge contributions include post-2007 research findings since the creation of the C-SSRS, such as the cultural model of suicide and cultural risk factors. Unfortunately, research does not offer a concrete pathway to choose an approach to screen a patient at risk of dying by suicide. Feedback from medical providers from the prior in-person presentations of this webinar indicated a need to operationalize the research from the field of suicidality to improve perspective-taking and cultural attunement.

Culturally-Grounded Interpersonal Model for Suicide Risk Assessment (C-GIMS)

C-GIMS incorporates the research in the field of suicidality, and the cultural, societal, and interpersonal contexts of an individual to comprehensively understand a patient's experience of suicidal ideation and determine the approach to screen for suicide risk. Choosing an individualized approach to screening for suicide is a facet of clinical judgment. When a medical provider understands a patient's experience of suicidal ideation in a holistic way, they can successfully choose an approach to screen for suicide risk. Further, patients may be more likely to disclose suicidal ideation. Medical providers can confirm their understanding of a patient's risk of dying by suicide through a patient's disclosure of suicidal ideation. In this way, a medical provider collaborates with their patient and can more accurately conceptualize the patient's risk of dying by suicide.

Durkheim's (1897/1951) sociological theory of suicide is a main underpinning for the development of the model. The first visual of the C-GIMS diagram incorporates Joiner's (2005) interpersonal theory of suicide. With its three constructs of perceived burdensomeness, thwarted belongingness, and a capability to die by suicide, Joiner's (2005) interpersonal theory of suicide provides the foundation for C-GIMS. Chu and colleague's (2010) cultural model of suicide fits within the three constructs of Joiner's interpersonal theory of suicide. Then, classical risk factors, cultural risk factors, and warning signs are added to C-GIMS within Joiner's three constructs. Protective factors are not meant to replace risk factors and are considered complimentary to C-GIMS (Joiner et al., 2007).

The C-SSRS does not differentiate interview approaches for a patient answering screening questions; however with the development of the C-GIMS, a medical provider will have an improved understanding of their patient's experience of suicidal ideation. Clinical judgment is informed by the following facets: knowing the factors that influence aspects of screening for suicide, knowing the advantages and disadvantages of a screening measurement, understanding a patient's risk of dying by suicide, and choosing an individualized approach to screening for suicide risk. The last facet of clinical judgment is conceptualizing the level of risk for a patient's death by suicide. When medical providers choose an individualized communication approach to screen patients at risk of dying by suicide, clinical judgment improves and there may be a chance for patient-provider collaboration.

Approaches When Screening for Suicide Risk

For this webinar, an approach is defined as the following: the communication style (cultural/interpersonal/technical), the stance (open/curious to closed/defensive), and the questions (reinterpretation of the questions from the chosen screener). Screening with the C-SSRS standard questions is a direct interview approach. Sometimes an approach to screening for

suicide will be a natural process. The empathy that comes from understanding a patient's experience of suicidal ideation may naturally lead to a culturally-attuned and interpersonal approach to screening for suicide. However, an individualized approach that considers subtle communication styles is not a part of the C-SSRS. The C-SSRS questions may be considered invasive and insensitive if not introduced with careful timing. A medical provider who wants to choose an individualized approach to screening for suicide needs to know of the different ways patients communicate.

Takahashi (1997) attested to the disadvantages of a direct interview approach. For example, medical providers often ask questions about suicide risk in a clear, concise, and direct manner; this approach is how medical providers are trained to communicate with other doctors, nurses, and staff, without realizing that patients may not communicate in the same way (Hallenbeck, 2006). Takahashi (1997) suggested waiting before asking directly about suicidal ideation and suicide attempts right at the beginning of a first session with a person who identifies with the Japanese American minority group, and that accepting a patient's silence does not mean they will not answer the question. Feldman-Stewart, Brundage, and Tishelman (2005) developed a framework for patient-provider communication, acknowledging there are different ways to communicate. Medical providers may assume patients speak in a similar manner as themselves. In reality, many groups of people who are not part of dominant, mainstream culture use subtle and non-verbal ways of communication to speak about sensitive topics (Sue & Sue, 2013).

Even generalized cultural dimensions within Europe predicted cross-national communication differences (Hofstede, 2001; Meeuwesen, Brink-Muinen, & Hofstede, 2008). Patient-provider communications in European countries where hierarchical roles were clearly defined and fixed had shorter consultations and fewer opportunities for unexpected informational exchanges. In Japan, Hall (1976) articulated that people who identified as Japanese convey

important messages in a non-direct manner. He stated that many individuals in Japan concealed inner emotions in public, but openly expressed feelings and communicated in private. In the United States, if a patient has a concern of high importance they may state it either directly, indirectly, verbally, or non-verbally.

If a medical provider is culturally-attuned, suicide risk screening can be conducted with more accuracy and become a collaborative screening. However, cultural identity is just one reason for the diverse way patient's communicate with providers. Gender socialization, English as a second language, and the intersection of multiple identities as described in Hays (1996) ADRESSING model (Age, Disability, Religion, Ethnicity, Social status, Sexual orientation, Indigenous heritage, National origin, and Gender) are noteworthy reasons for diverse communication styles. Other reasons are cultural complexities like globalization, post-colonization, cultural ambivalence (dueling cultural values), and assimilation/acculturation (Im et al., 2018; Kim, 1990; Park, 2013; Park et al., 2014; personal communications, Sine Anahita, February 9, 2018).

CASE Approach. Dr. Shea created the Chronological Assessment of Suicidal Events (CASE) approach to help assess, through interviewing skills, if a patient is experiencing suicidal ideation (Shea, 1998, 2007, 2009, 2012, 2017). The CASE approach is helpful regardless of the type of assessment a medical practice uses to screen for suicide because it can be individualized, and doctors may choose to use the CASE approach to fit their protocols (Shea, 2012, 2017). The CASE approach can be used for a structured assessment like the C-SSRS (Shea, 2012) since the five different interview techniques (behavioral incident, gentle assumption, denial of the specific, catch-all question, and symptom amplification) can be used interchangeably throughout the screening. Normalizing, shame attenuating, and inquiring are three additional interview techniques that may be used in conjunction with the CASE approach as well.

CASE interview techniques. The CASE approach includes five techniques: behavioral incident, gentle assumption, denial of the specific, catch-all question, and symptom amplification (Shea, 2012, 2017). The behavioral incident technique focuses on behaviors, thus reducing the feeling of judgment when inquiring about suicidal ideation. This technique is a set of queries for facts, behaviors, or thoughts in a sequence of events that may lead a patient to disclosure of sensitive topics (Pascal, 1983; Shea, 2012). One example of the behavioral incident technique after a patient disclosed they attempted suicide is to ask, "What happened next?" or "Then what happened?" instead of stating an opinion or exclamation. Pascal (1983) noted that placing the person in the position of "observer" results in interviewees being more reliable (p. 9). However, it is important to evaluate the answers from the behavioral incident technique since patients may have subjective opinions about suicidal ideation or suicide attempts and distort the information as a protective mechanism (Shea, 2012).

Gentle assumption can be used if a patient is hesitant to discuss a topic. Shea (2012) incorporated gentle assumption in the CASE approach from Pomeroy (1982), who wrote "suggesting answers" should be avoided, but having a range of varied possible answers can elicit a response from the patient (Pomeroy, 1982, p. 18). For example, one could assume suicide is a taboo topic and ask in a gentle voice, "What other ways have you thought about killing yourself, if at all?" or "When was the last time you had thoughts about suicide?" One could ask a second time, in a lower tone or different intonation when asking, "Have you had any fleeting thoughts of killing yourself, even for a moment or two ?" (Shea, 2012, p. 35). This technique to help patients share sensitive information is useful; however, it could also result in leading questions. This technique requires cultural competence. A patient may feel intimidated by someone in a position of authority and may attempt to answer what they think the authority figure wants to hear (Shea, 2012).

The denial of the specific technique is used to uncover suicidal ideation with specific suicide attempts (Shea, 1998, 2017). For example, "Have you thought of shooting yourself?" instead of a general question such as, "Have you ever thought of dying?" offers a concrete occurrence of suicidal ideation (Shea, 2012, p. 36). The catch-all question technique is used to determine if any suicidal ideation was missed (Shea, 2017). Shea (2012) offers this example: "We've been talking about different ways you've been thinking of killing yourself. Are there any ways you've thought about that we haven't talked about?" (p. 37). The last technique, symptom amplification, sets the upper limit of the number of suicidal behavior or attempts (Shea, 2007, 2017). For example, a medical provider would ask, "How many times did you take more than the recommended dose of Tylenol in the past month…two times, five times?" If the patient minimized the problem by stating they overdosed on medication twice in one month, then the clinician would know there was a significant concern for suicide attempts in the future.

Normalizing, shame attenuating, and inquiring. Three other techniques that are helpful for culturally-attuned communication when screening for suicide are: normalizing, shame attenuating, and inquiring. Normalization and shame attenuation are two additional techniques used by the CASE approach that increase the validity of a patient's answers by reducing stigma and shame of suicide throughout the screening interview (Shea, 2012). Normalization is to phrase a question so that the patient does not feel like there is something wrong with their reactions (Shea, 2012). An example is, "Sometimes when people are in a tremendous amount of pain, they find themselves having thoughts of killing themselves. Have you been having thoughts like that?" (Shea, 2012, p. 35). A statement directed toward a patient diagnosed with a disease, such as cancer is: "Some people with cancer have suicidal thoughts; please let me know if that is happening with you. I can help you and you don't have to suffer alone" (Cooke et al., 2013).

Shame attenuation is another technique used to approach a client in a culturally-sensitive way (Shea, 2012). For example, you could ask: "With all of your pain, have you been having any thoughts of killing yourself?" (Shea, 2012, p. 35). It is important to consider how the patient may actually speak to themselves. Would a person really tell themselves, "I am going to commit suicide," or is it more likely they will say to themselves, "Maybe I should just kill myself" (Shea, 2012, p. 35)? Additionally, using the term "commit" implies a crime was committed or a law was broken and has a negative connotation (Shea, 2012). Generally, mainstream dominant society views suicide as wrong. Medical providers are in a place of authority in mainstream dominant society. Medical providers using words that imply illegal activity amplifies feelings of guilt and shame, which can lead to non-disclosure of suicidal ideation.

One way to avoid guilt and shame associated with suicidal ideation is inquiring about a patient's mood. Asking about a patient's mood can open discourse that leads to disclosure of suicidal ideation. For example, a provider could ask a patient about their mood and if they would rate their mood on a Likert scale. A provider could also ask what occurred in their lives that caused them to rate their mood at that score (Sommers-Flanagan & Shaw, 2017). This is an important technique in screening for suicide because a patient may not realize they are experiencing suicidal ideation. They may be in denial because they do not know their specific thoughts qualify as suicidal ideation in relation to their mood. One way to assist a patient to become conscious of their need for help is through an approach where an inquiry leads into a discussion. Through this discussion, a patient may conclude that they experienced suicidal ideation, they do not want to die, and they will collaborate with their medical provider for additional services (Shea, 2012).

In summary, improving clinical judgment through understanding a patient's experience helps a provider choose an interview approach. An individualized approach: the communication

style (cultural/interpersonal/technical), the stance (open/curious to closed/defensive), and the questions (reinterpretation of the questions from the chosen screener), for suicide risk-screening offers flexible interview skills for a diverse population. If one views communication on a spectrum between cultural, interpersonal, and technical, there are many different interview techniques that fall within this scale. Medical providers can use the standardized questions in the C-SSRS or adjust the questions as suggested by the CASE approach as well as use normalizing, shame attenuating, and general inquiry. Having used an individualized approach to screening for suicide risk, collaboration with patients to develop an aftercare plan can more likely occur.

Aftercare

Aftercare is the coordinated follow-up of a treatment plan that was agreed upon as part of the discharge from a medical setting (Shand, Vogl, & Robinson, 2018). Patients who are at risk of dying by suicide need empathy, kindness, and a commitment from hospital staff, primary care, and specialist care providers to support following through with aftercare plans (Shand et al., 2018). Hill, Shand, Torok, Halliday, and Reavley (2019) suggested that the attitudes of staff in acute medical settings should be a priority. McKay and Shand (2018) identified five themes that helped a patient follow aftercare plans following an attempt of suicide: fitting into the healthcare system (at times their cases were considered too complex or the physical care was not integrated with the mental health care); consistent care (caregiver saw the same person each time); need for advocacy (inability to seek help and follow-up on promised services); luck to find help (private compared to public health care and appropriate care for their emotional and financial needs); and small gestures of kindness. Small gestures of kindness, like providing a room for rest or privacy, was a concrete example of empathy toward patients and offered patients a sense that medical staff supported and cared for them (McKay & Shand, 2018).

Hill and colleagues (2019) noted that in spite of their importance, small gestures of empathy are difficult to clarify in an aftercare policy. Hill and colleagues (2019) were studying and identifying best practice strategies for follow-up care in acute medical settings for patients who experienced suicidal ideation. Hill and colleagues (2019) conducted a study with two research panels: one panel with health professionals and a second panel with patients. The panels rated essential and important items to consider for aftercare. The following list of elements for an aftercare plan was included if both panels were in at least 80% agreement with each other: initial contact, assessment, referral, discharge, follow-up (an agreed treatment plan upon discharge from a medical setting), staff training, and connections to community aftercare services. The researchers identified aftercare elements for patients at risk of dying by suicide: immediate and aggressive follow-up after a patient was discharged from a medical setting, ongoing risk assessment, ongoing planning, encouragement to attend treatment, problem-solving based counseling, and a combination of contact by one staff trained in mental health for a span of six to twelve months.

Aftercare for patients. Aftercare was an issue for Fairbanks North Star Borough medical providers, based on healthcare providers' concern about referrals for patients (Goldstream Group Incorporated, 2017). Medical providers wanted more information to refer patients to mental health services in the Fairbanks North Star Borough. There is a worker shortage among mental health clinics in the area, making it a challenge to find affordable and flexible mental health care. There are less options for services for patients who do not have private insurance or who cannot afford the insurance deductibles. At times, the waitlist for some local mental health service clinics have been three to six months long, depending on the type of service requested. The challenge to locate services can be disconcerting and why it is important

to know what services to request for before attempting to refer in an environment with a worker shortage.

Using psychiatry research for content to support medical providers' aftercare services offered a mental health professional's perspective for medical providers who may not be aware of aftercare management: the most important step to aftercare, kinds of therapy needed when referring patients to counseling services, and why these steps are important to follow. To improve patient aftercare ensuing a suicide attempt, Shand and colleagues (2018) in the field of psychiatry recommended following four steps: assertive follow-up after a patient is discharged from the hospital, continuing risk-assessment and planning, patient encouragement to follow the aftercare plan, and solution focused brief therapy.

First, a patient needs a psychosocial assessment for comprehensive care because it provides a framework for the aftercare plan. Shand and colleagues (2018) explained that many patients do not receive a psychosocial assessment, even when it provides the information needed to facilitate comprehensive care. A medical provider can refer patients to mental health providers to complete a psychosocial assessment. Aftercare management includes preparing releases of information so that referrals can be made to mental health providers who offer a psychosocial assessment and to receive the results from the psychosocial assessment. Then, aftercare includes ongoing risk assessment and planning. For example, flagging a patient's medical chart to indicate a patient's experience of suicidal ideation is an important step to aftercare. A medical provider can track changes in the patient's chart using the C-SSRS. The next step is to encourage the patient to follow treatment and to provide motivation to attend referral appointments. The last component of aftercare is brief therapy using a solution-focused approach for patients to develop more adaptive coping strategies.

Consultations are a form of contact with medical providers who can offer support for a patient navigating the medical system. Positive and empathetic healthcare experiences, as well as connection services, assist the recovery of people who have attempted suicide. For example, Grimholt and colleagues (2015) demonstrated that patients who received structured follow-up as part of an aftercare plan received significantly more consultations and were more satisfied with the time the general practitioner provided to listen to their problems. In addition, patients were more satisfied with treatment overall. Luxton, June, and Comtois (2013) evaluated the literature on follow-up contacts and concluded that repeated follow-up contacts with patients reduced suicidal risk and suicidal behaviors. Luxton and colleagues (2013) stressed successful aftercare for patients required time. For example, the referral process with coordinated management of care from other health care services is time-intensive (Grimholt et al., 2015).

Aftercare for medical providers. Medical providers need time for their own care. Time is especially important when a patient dies by suicide. Clark, Smith, Griesbach, Rivers, and Kuliwaba (2020) highlighted a set of guidelines developed to support doctors and staff after a patient dies by suicide, which are similar to the aircraft emergency practice of fitting the oxygen mask on oneself before aiding a passenger. As a caveat, Clark and colleagues (2020) noted it was difficult to gather information because of the stigma associated with suicide. Their guidelines proposal was limited to collecting data from one practice in a high socioeconomic suburb in Australia. It is important to keep in mind that the practice settings in the Fairbanks North Star Borough may be different from the one setting described by Clark and colleagues (2012).

Clark and colleagues (2020) acknowledged that little research has been conducted on this topic. However, there is existing literature that is available for psychiatrists that may also be helpful for physicians. There is a wide range of responses by psychiatrists when a patient dies by suicide (Gitlin, 1999, 2012; Menninger, 1991; Sacks, 1989; Tillman, 2006). Gitlin (2012)

revealed certain factors impact the severity and frequency of reactions to a patient's death by suicide. The intensity of the relationship—including if the psychiatrist was the only treating provider of care—influences a psychiatrist's reaction. The individual personality of the psychiatrist and the length of their career can also affect their response to the death of a patient by suicide. Clark and colleagues (2020) emphasized that the intensity of a provider's feelings was oftentimes related to the intensity of the patient-provider relationship as well. Gitlin (1999) and Sacks (1989) categorized reactions to patient suicide into two parts: the initial reactions and the second-phase reactions. On the other hand, Clark and colleagues (2020) did not distinguish between initial and secondary reactions.

Clark and colleagues (2020) listed the emotions medical practitioners may experience: guilt, grief, failure, anger, fear of facing the bereaved family, stress and trauma reactions, doubt about their ability to continue working in the profession, and fear of litigation. Sacks (1989) added that initial reactions for psychologists include shock and disbelief. Gitlin ((1999) mentioned denial and dissociation as well. Secondary reactions include grief, shame, guilt, fear of blame, anger, relief, fear of lawsuit, looking for missed signs of pending death by suicide, and concerns of professional competence (Gitlin, 1999; Tillman, 2006; Menninger, 1991). One reaction that needs further explanation is a "sense of specialness" (Gitlin, 1999, p. 1632). A "sense of specialness" is a conflict of feelings experienced by a provider that may include their feeling isolated from other medical providers because of their patient's death by suicide, while concurrently feeling part of a special group of medical providers who have experienced the same thing. Meanwhile, Sacks (1989) explained this "sense of specialness" as a result from peers' responses. The psychiatrist may feel shunned by other providers who have not experienced a patient's death by suicide, or may have an illogical belief they are recognized solely by the death of their patient. Sacks (1989) explained finding omens as a sense of guilt causing a psychiatrist

to think they had a premonition their client would die by suicide, but failed to act. Gitlin (1999) noted that not all professionals will exhibit these reactions, and the order of reactions may be different for each individual.

Gitlin (1999, 2012) outlined four methods of coping for psychologists who have experienced the death of patients. Listed are the following strategies: decrease isolation, challenge thinking errors with cognitive theories, temporarily change behaviors, and build restorative behaviors. Gitlin (2012) offered an unexpected way to decrease isolation. He suggested that presenting the topic of patient deaths by suicide at conferences and meetings is a viable option that could decrease the feeling of isolation while providing a safe place to discuss experiences (Gitlin, 2012). In addition, speaking with former teachers, trusted colleagues, friends, and family reduces isolation (Gitlin, 1999). Gitlin suggested (1999) cognitive theories (accepting philosophical viewpoints regarding the death of a client by suicide) to challenge thinking errors as a second method to reduce guilt and pain and help manage intense emotions. The third method was to create a policy for restorative behavior, such as having more experienced professionals available to support less experienced colleagues with processing the death of a patient by suicide. The next method of coping with a patient suicide is temporary changes in behaviors. One example offered for psychiatrists was to temporarily refer patients at high risk of dying by suicide until the psychiatrist's distress was diminished.

Meanwhile, Clark et al. (2020) listed five methods to support doctors and staff with the death of a patient by suicide: acknowledge emotions, seek support from other practice staff, seek legal support from a medical indemnity lawyer, consider consultation with other providers who cared for the deceased person, and practice self-care. The first method of support for medical doctors and staff consisted of acknowledging that emotions like grief, guilt, shame, anger, fear and failure are normal. The second method is to find support from medical providers and staff.

The researchers highlighted the importance of support from family, friends, peers, and their own general practitioner, as well as considering professional counselling. Next, seeking legal support from a medical indemnity lawyer was recommended. Clark and colleagues (2020) expressed that the perception of risk related to being sued is oftentimes greater than it actually is, and to work with suicidal patients takes courage. The fourth method is to consult with other providers who cared for the deceased person, as it can be mutually reassuring and may answer questions the medical provider may have about the patient who died by suicide. Self-care is the last method to support medical providers and staff after experiencing a patient dying by suicide. They recommended a brief absence from practice and lifestyle changes: exercise, sleep, diet, socializing, activities, and practicing coping strategies.

In summary, there are challenges to aftercare treatment as patients who are psychologically fragile must navigate a healthcare system that is demanding. Given the interdisciplinary approach to aftercare plans, having a point of contact is helpful. Patients may need to attend different clinics and meet with new service workers. Aftercare planning requires coordination and cooperation between service providers. It takes time to handle the release of information forms (including time to contact different providers and following up with patients), but the literature shows positive patient outcomes as a result of diligent aftercare planning.

Meanwhile, Fairbanks North Star Borough medical providers have concerns about the referral process. In particular, whom to refer during a workforce shortage. Literature in the domain of psychology can inform medical providers what services to request when referring patients to mental health services. Requesting a mental health provider who can conduct a psychosocial assessment, a counselor who specializes in Solution-Focused Brief Therapy (SFBT), and a person trained in mental health to contact a patient while they are attending

aftercare appointments for a period of six to twelve months as a support for patients who may experience challenges to follow their aftercare plan is recommended (Shand et al., 2018).

Psychologists and medical providers who experience the death of a patient by suicide can have intense emotional reactions to the sudden loss (Clark et al., 2020; Gitlin, 1999, 2012; Menninger, 1991; Tillman, 2006). Given the intense reactions recorded in literature, medical organizations should create an aftercare plan for medical providers. Medical providers, like psychologists, may experience intense emotions and even trauma-like symptoms. Consider a patient who left an acute hospital setting with a negative experience and felt vulnerable. The patient called their general practitioner and their general practitioner cancelled all appointments to arrange different referrals, spent time with the patient, and set up follow-up appointments with them (McKay & Shand, 2018). If this medical provider, who showed empathy and kindness, lost this patient to suicide, the provider would not be immune to the pain of their patient's death.

Summary of Key Findings

Medical providers are influenced by personal philosophies, the law, implicit biases, and training. Medical providers who screen for suicide risk need to be aware of these influences. Research shows that hidden biases influence healthcare and findings indicate a need to improve communication. Current practice in the field of suicidology is to combine screening assessments with clinical judgment. The five facets of clinical judgment are: knowing factors that influence screening for suicide risk, knowing the positive and negatives of screening measurements, understanding a patient's experience of suicidal ideation, choosing an approach to screen for suicide risk, and conceptualize the patient's risk of dying by suicide. Practicing self-awareness, recognizing philosophical differences, challenging hidden biases, and attending training are ways to improve this first facet of clinical judgment.

The second facet of clinical judgment is to know the advantages and disadvantages of the screener used to measure a patient's risk of dying by suicide. There are many types of suicide screening

measures. Unfortunately, there is not just one screener that encompasses every aspect of suicide. The C-SSRS is the closest to the gold-standard. It is the Food and Drug Administration standard for measuring suicidal ideation since 2012. However, the C-SSRS does not focus on understanding a patient's experience of suicidal ideation or offers a flexible interview approach. Research indicated there was a problem with inter-rater reliability of the C-SSRS as results were impacted by misinterpretations in communication. Combining the C-SSRS with solutions for the issues of inter-rater reliability and a lack of a flexible screening approach will improve clinical judgment. Next, in an effort to improve inter-rater reliability, a review of the literature focused on understanding suicide.

Understanding a patient's experience of suicide is another facet of clinical judgment. There are several concepts delineated in the training to support understanding a patient's experience of suicidal ideation: sociological theory of suicide, interpersonal theory of suicide, the cultural model of suicide, risk factors, warning signs, and protective factors. The concepts delineated in the training guided the development of C-GIMS. C-GIMS supports choosing an individualized approach to screening for suicide through the incorporation of new findings in the literature with classic knowledge in the field of suicidality. When a medical provider knows the context of a patient's life that may have precipitated suicidal ideation, they can empathize with the patient's experience. Understanding the patient's experience of suicidal ideation will aid in choosing an approach to conceptualize the risk of death by suicide and is another facet of clinical judgment. With a flexible interview approach, communication can be individualized with the optimal result being a conceptualization of a patient's risk of dying by suicide. In collaboration between patient and provider, the conceptualization will likely lead to the development of an aftercare plan.

Aftercare plans can be collaborative as well, and with the facets of clinical judgment established with the medical provider's conceptualization of the patient's risk of dying by suicide, an aftercare plan can be agreed upon. With Fairbanks experiencing a mental health care workforce shortage, it is

important to know which services need to be referred and why those services are needed in the aftercare plan. The most important element of a plan is a psychosocial assessment conducted by a mental health care specialist as the results guide types of services and referrals required for patient care. It takes time for medical practitioners to assist in a patient's mental health crisis, coordinate care, and maintain a follow-up schedule to contact a patient, but literature indicates positive outcomes for the patient's wellbeing. It also takes time for medical providers to consult with more experienced medical providers, an important element of provider self-care when working with a patient at high risk of dying by suicide. As medical providers begin to screen for suicide in their practices, it is important to anticipate common responses from medical providers reacting to a patient's death by suicide and strategies to mitigate their distress.

Application

Dissemination of this research project is in the form of a 1.5 CME training webinar for medical providers who practice in the Fairbanks North Star Borough. The title of the webinar is "An Interpersonal Approach when Screening for Suicidality in Medical Settings." The webinar was developed in three phases: 60-minute video recording for six key informants, an in-person 90-minute training presentation for 1.5 CME, and a second in-person 60-minute training presentation for 1.0 CME. The feedback from the three phases of development led to the conclusion that screening for suicide in medical practices requires a screening measurement based on an ideation-to-action theory of suicide, an understanding of a patient's experience of suicidal ideation, and a flexible approach to screening for suicide that enhance clinical judgment. The content for the training includes development of self-awareness, the C-SSRS, knowledge from the literature in suicidology, C-GIMS, an individualized approach for suicide risk screening, and aftercare for patients and providers.

The objective was to improve screening for suicide in medical settings by improving clinical judgment. The facets of clinical judgment enhances a medical provider's self-awareness, perspective-taking, and cultural attunement. The C-SSRS combined with C-GIMS is meant to support a flexible, individualized, interpersonal, culturally-attuned interview approach for suicide risk screening. Attached in the Appendix is the webinar that was developed using the Canvas Infrastructure platform. The Canvas platform allowed the webinar to be broken into several parts: a homepage with an introduction to the webinar; a pre-training video vignette within a medical setting capturing a typical patient experience during an impersonal and ineffective screening process for suicide with a pre-training survey; a presentation of the training material embedded into a video recording of the webinar divided into three sections; two presentation handouts; a suicide prevention tool box where resources are located; a post-training video vignette depicting a patient's experience with a provider who uses C-GIMS and an individualized interview approach for suicide risk screening with a post-training survey; artwork by Ciara Pitka and a video vignette of the artist for a visual metaphor of suicide risk factors; an evaluation of the overall webinar experience; and two discussion boards.

The PowerPoint was embedded into the video recording with the presenters who discussed the content in the presentation. The PowerPoint presentation includes relevant statistics, factors that influence medical providers to screen for suicide risk, the C-SSRS, and how the C-SSRS is structured using Joiner's interpersonal theory of suicide, the cultural model of suicide, risk factors, warning signs, protective factors, C-GIMS, an interview approach to screening for suicide, the referral process, aftercare for patients, and aftercare for medical providers. During the video recording using a pointer within the PowerPoint program, a localized example was used to demonstrate C-GIMS. Examples of interview techniques to screen patients for suicide risk were demonstrated. Material describing the advantages and disadvantages of the

C-SSRS illustrated why the webinar content was chosen. Local referral information and the procedures for aftercare were explained. Artwork and a video vignette made by artist Ciara Pitka was included to offer a local, high-school student's perspective about suicide screening and a visual metaphor of suicide risk.

Conclusion

There is a need to screen for suicide risk in medical settings in the state of Alaska. Findings in the literature indicated that training was a way to improve screening patients for suicide risk. The literature does not suggest specific content for a suicide screening training. The research question used to create a training for medical providers was, "What do medical providers need to know in order to improve screening for suicide in their practices?" The literature indicated that the current practice is to combine assessments with clinical judgment. Content for the webinar was researched to include facets of clinical judgment: factors that influence screening for suicide (self-awareness), the C-SSRS (screening and assessment in the field of suicidality); cutting-edge and classical research in the field of suicidality (understanding a patient's experience of suicidal ideation); C-GIMS (individualized approaches when screening for suicide risk); and aftercare practices (a comprehensive conceptualization of a patient's risk of dying by suicide).

This author resolved the gap in the literature with the development of the webinar, "An Interpersonal Approach When Screening for Suicidality in Medical Settings: A Review of Best Practices" and the creation of C-GIMS to connect best screening practices in the field of suicidality: a screening measurement and clinical judgment into a concrete framework to conceptualize a patient's risk of dying by suicide. Medical providers in the Fairbanks North Star Borough desired information about the referral process (Goldstream Group Incorporated, 2017). This author hoped to resolve the gap in the referral process for local medical providers by

discussing the referral process and development of aftercare plans. Providing local resources in the Suicide Prevention Tool Box supports medical providers with the referral process (see Appendix).

A multicultural and social justice approach was important to the development of this webinar. It is imperative to screen patients of color and patients who identify with a sexual minority group effectively for suicide risk in medical settings. The webinar can improve screening for suicide risk in medical practices because it included C-GIMS, an attempt to incorporate cutting-edge contributions with current practices in the field of suicidology. For people who do not identify with mainstream dominant culture, "An Interpersonal Approach When Screening for Suicidality in Medical Settings: A Review of Best Practices" and C-GIMS offers medical providers a flexible approach to screen for suicide risk in an inclusive way.

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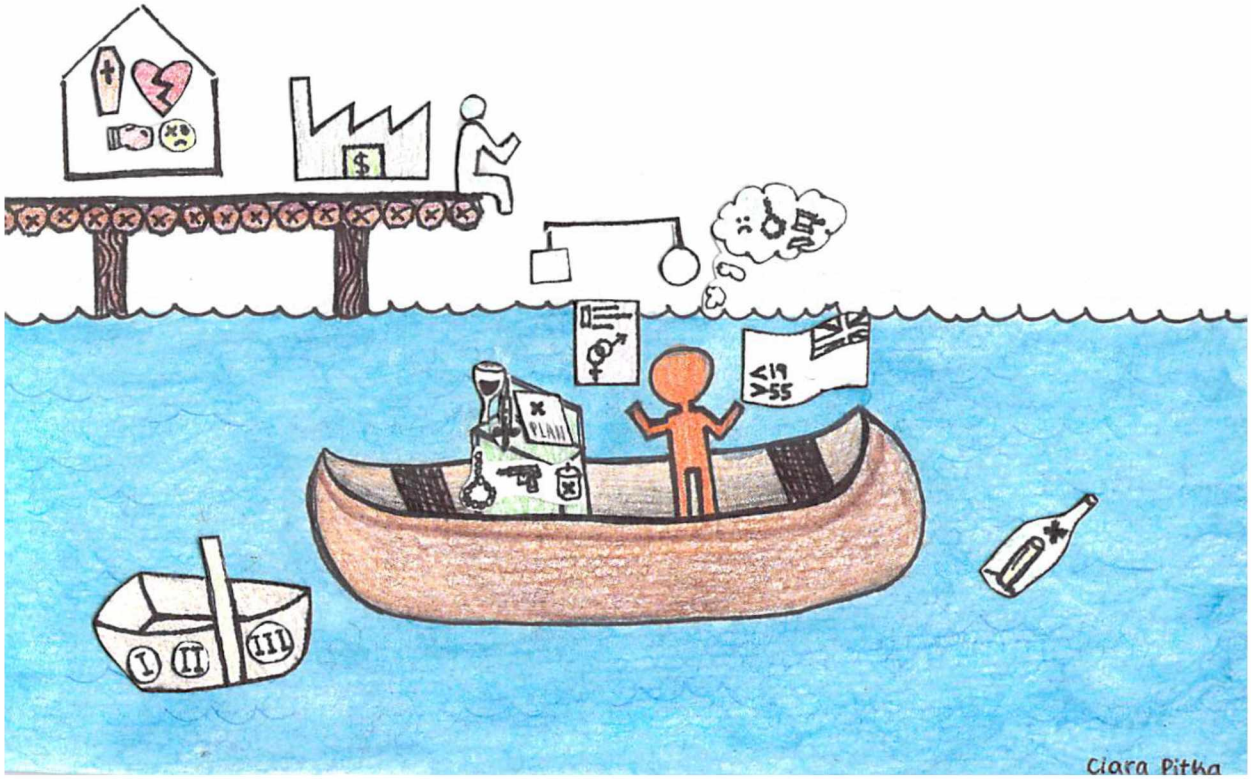
Appendix: Webinar

Interpersonal Approach when Screening for Suicidality in Medical Settings

By

Tomi L. Winters University of Alaska Fairbanks



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Appendix: An Interpersonal Approach When Screening for Suicidality in Medical Settings

This webinar is a 1.5 CME for medical providers who practice in the State of Alaska entitled "An Interpersonal Approach when Screening for Suicidality in Medical Settings." The webinar developer used Canvas Infrastructure, an intuitive web-based learning program, that offers medical providers seamless instruction of the content. A Microsoft PowerPoint presentation was embedded into a video recording for the webinar. The presentation was separated into three parts and turned into three modules.

In Webinar: Part I, a video recording includes an introduction and statistics from Fairbanks North Star Borough and the State of Alaska. Then, a review of the opportunities for medical providers to screen for suicide risk in their practices, a brief overview of the presentation, and an introduction to vignette one end the first module. Next in the webinar is Survey: Part I. Medical providers view a video vignette depicting a patient's experience of a typical screening for suicide risk in medical settings. In this section of the webinar, medical providers have an opportunity to express their thoughts about the video vignette and apply their current knowledge about suicide risk using the video vignette. Discussion Board I is for medical providers to post messages about their perspective of the short vignette.

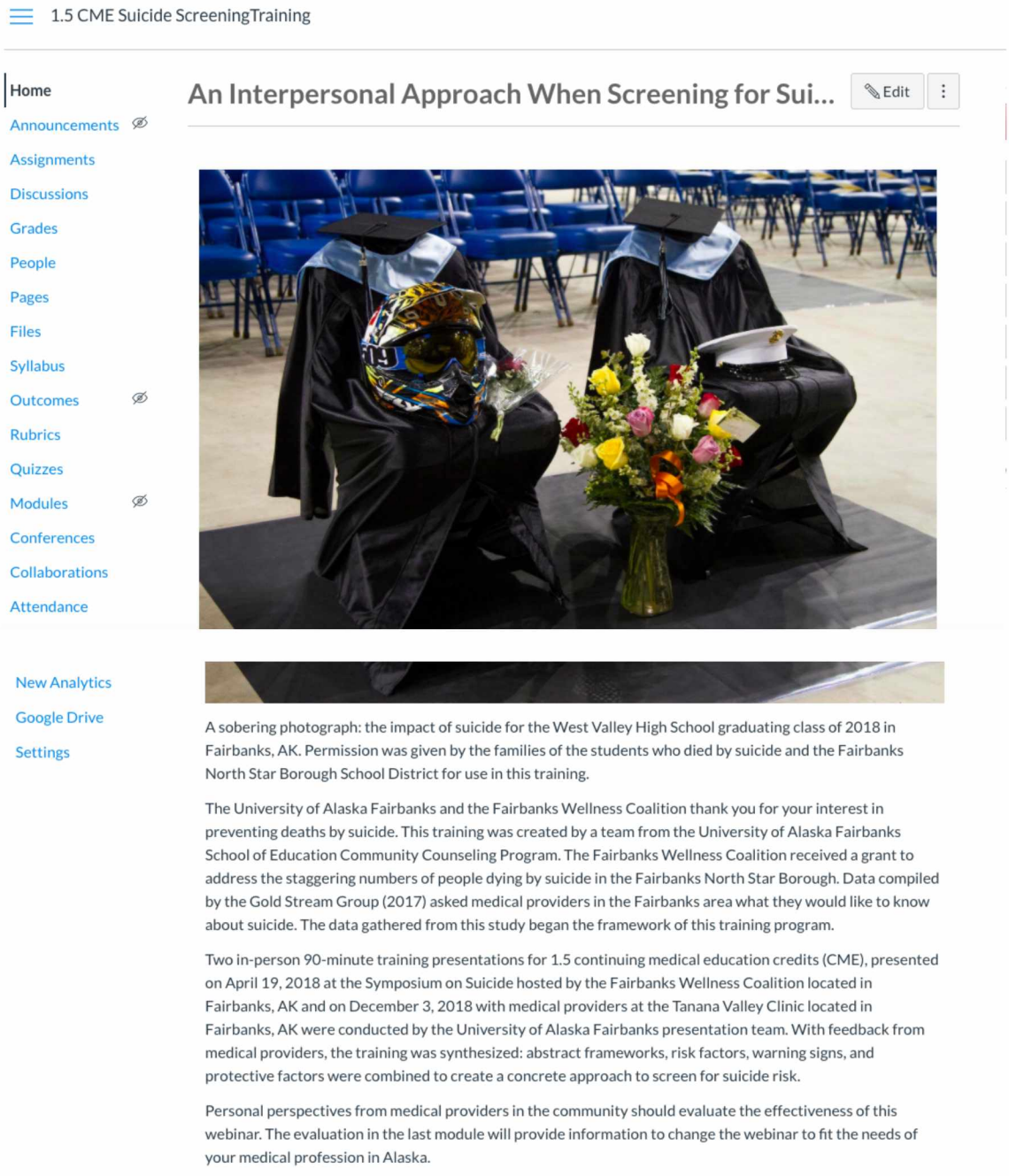
Webinar: Part II contains the bulk of the content. The second module contains the second part of the presentation and two presentation handouts. The PowerPoint presentation for Webinar: Part II includes slides delineating the factors that influence providers to screen for suicide and the advantages and disadvantages of the C-SSRS. In the video recording, the presenters explain the need for C-GIMS and an individualized approach when screening patients for suicide risk. The first handout illustrates how C-GIMS functions. Joiner's interpersonal theory of suicide, the cultural model of suicide, cultural risk factors, classical risk factors, and warning signs are detailed and incorporated into C-GIMS. A culturally-attuned and interpersonally modified set of questions from the C-SSRS is the second handout. The next section is Survey: Part II. This section has a post-training video vignette depicting a patient's experience with a provider who uses the knowledge from this webinar. In Survey: Part II, medical providers have an opportunity to express their thoughts about the video vignette and apply their post-training knowledge about suicide risk. Discussion Board II is for medical providers to post messages about their perspective viewing the short vignette.

Webinar: Part III includes the third part of the video recording with the embedded PowerPoint presentation, a link to a visual metaphor ("Suicide is Like a Journey" created by Ciara Pitka), and a video recording of an interview with the artist. In Webinar: Part III, the presenters inform medical providers about follow-up procedures for patients, aftercare procedures for patients, and aftercare for medical providers who experience a death of a patient by suicide. The last section is an evaluation of the webinar. Medical providers have an opportunity to guide further development of this webinar as the evaluations for feedback will be reviewed to determine updates and additional content for the next webinar.

The Suicide Prevention Tool Box module links to the C-SSRS, a pediatric references screening measurement titled, "Ask Suicide Screening Questions (ASQ) for Healthcare Providers," the UAF Community Mental Health Clinic's Community Resource List, a public licensed professional reference list for local medical providers in the Fairbanks North Star Borough, and a link to a Suicide Prevention Tool Box located in a shared Google Drive that contains the resources found in the Suicide Prevention Tool Box, handouts from the webinar, additional references not discussed in the presentation, and Ciara Pitka's artwork.

Canvas: Homepage

The first section of the webinar using Canvas Infrastructure is “An Interpersonal Approach when Screening for Suicidality in Medical Settings” and it is the “Home” (homepage) for the webinar. The “Home” consists of an introduction and overview for the webinar. The introduction in “Home” provides a local perspective for this webinar. The picture highlights the seriousness of this webinar and the impact deaths by suicide have in the Fairbanks North Star Borough community. On the left-hand side of the homepage are links to easily connect to the webinar content. In addition, there are links at the bottom of the homepage that will take the medical provider to each module. Each link on the bottom of the homepage are linear steps toward the completion of this webinar.



Webinar Part I

Survey: Part I

Webinar Part II

Survey: Part II

Webinar Part III

Suicide Prevention Tool Box

Training Evaluation

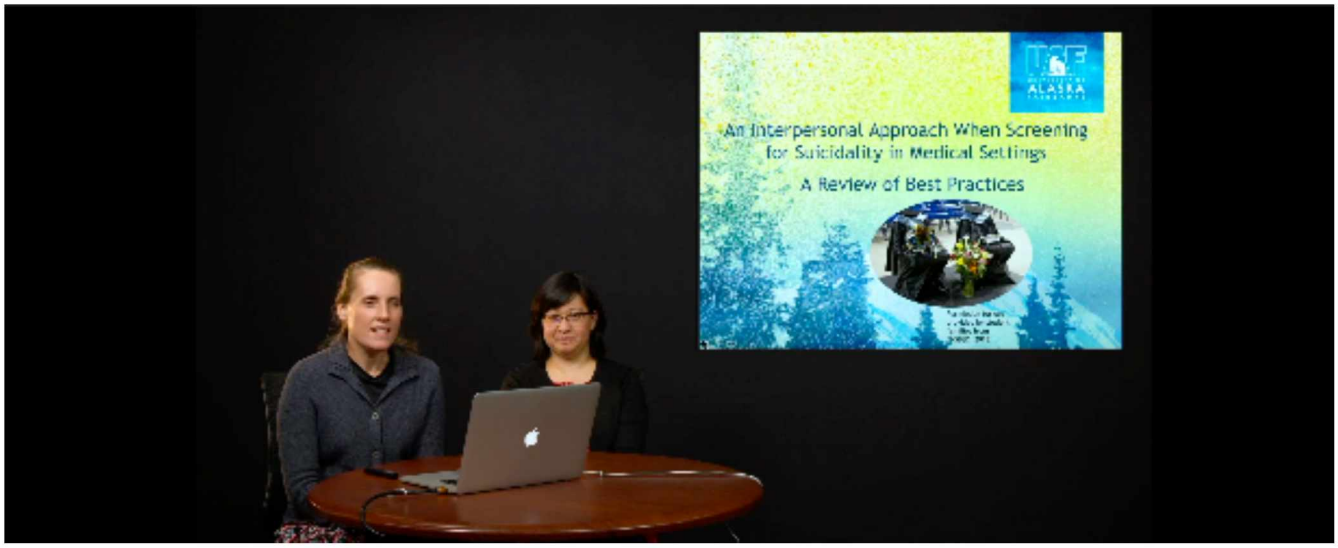
Webinar: Part I

Webinar: Part I consists of the first part of the PowerPoint presentation (slides 1-5). The slides include the title page, "Creating a Localized Training Program for our Medical Providers," "Screening in Primary Care Practices," "Overview," and an introduction to vignette one. The presenters speak to the medical providers throughout the presentation, offering a personal connection and exhibiting warmth within the webinar. Considering the webinar's title as an interpersonal approach to screening for suicide risk, it was important for the presenters to offer an example of interpersonal communication through conversation between two people. The slides seamlessly transition as the presenters discuss the content.

Webinar Presentation Part I

Link

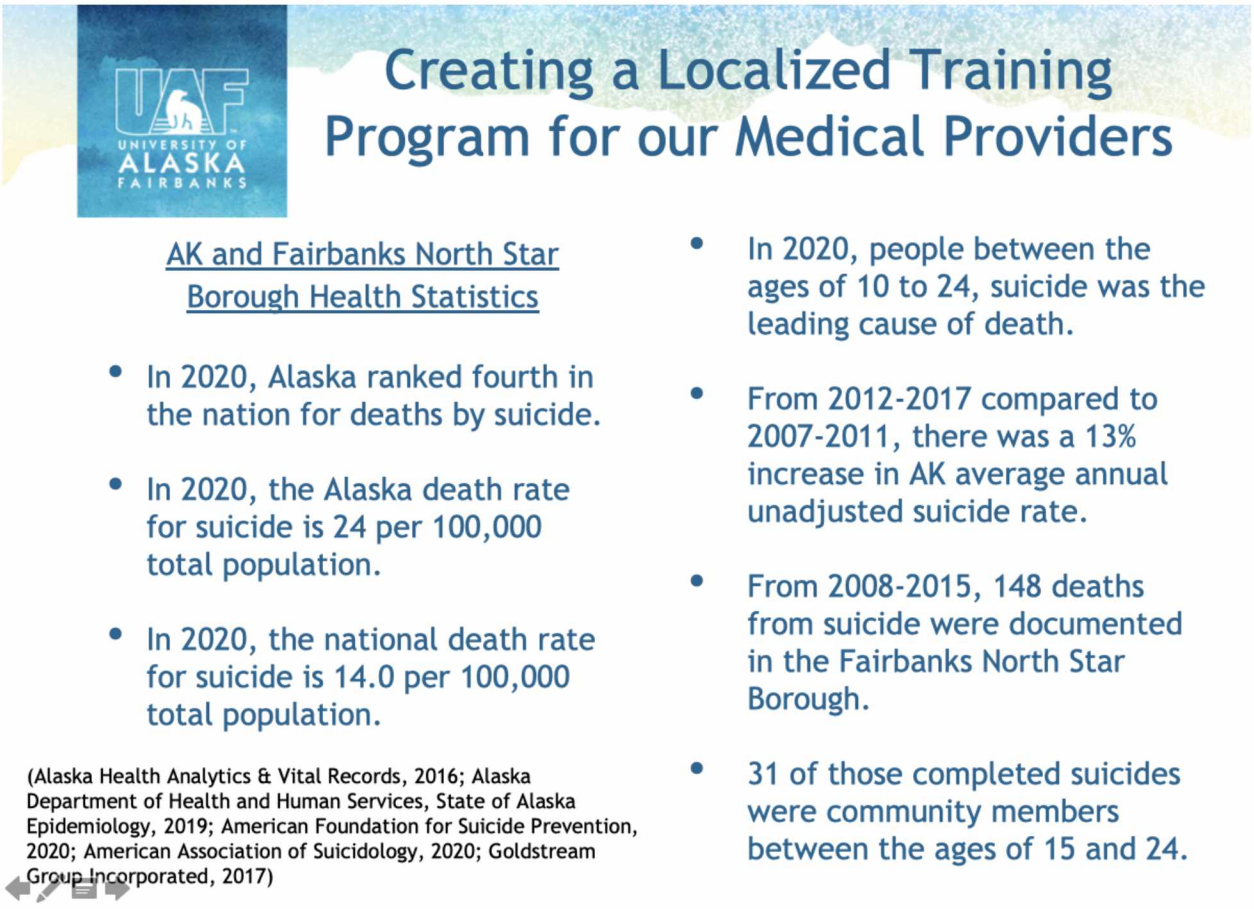
Please click on the link above to open the video recording of the presentation.



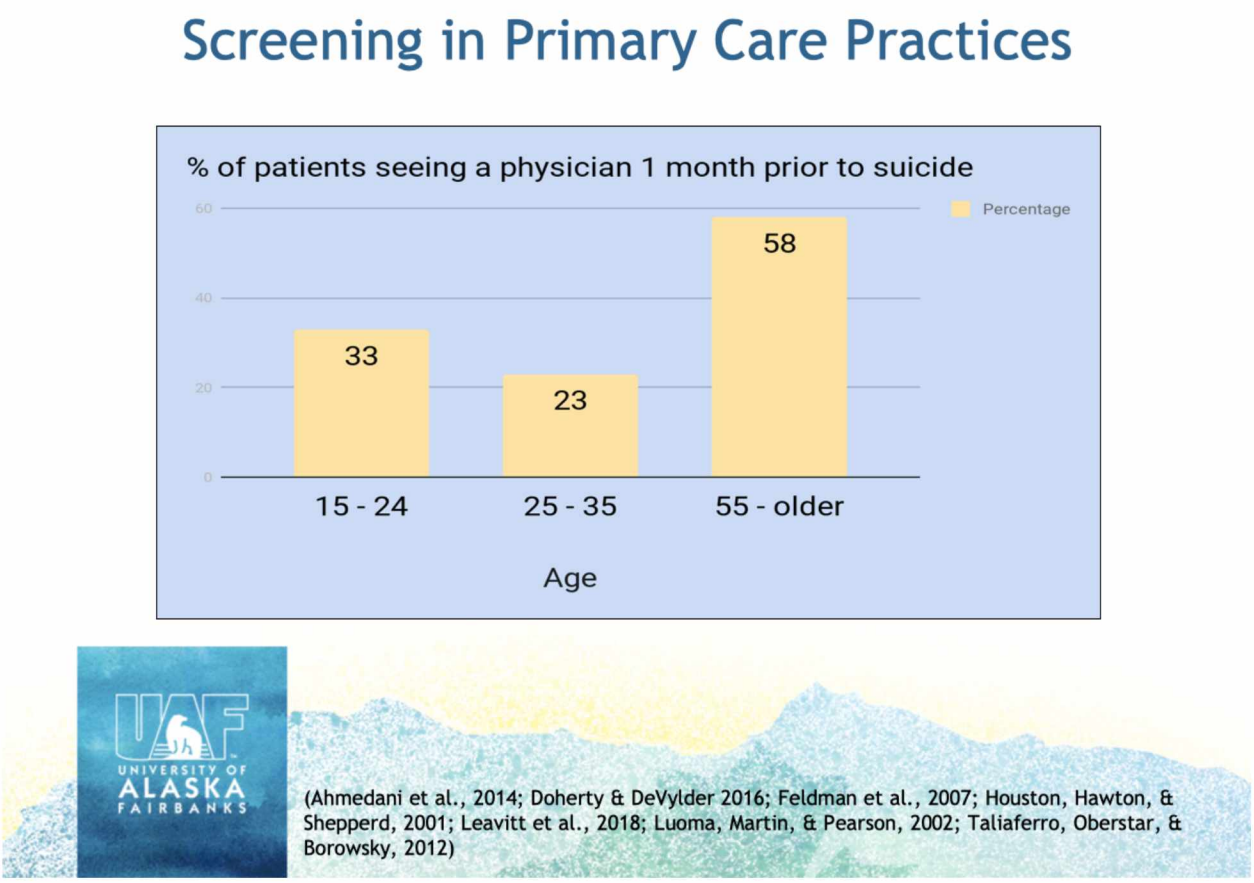
Webinar Part I PowerPoint Presentation, Slides 1-5

Slide one is the title page and is comprised of an introduction of the presenters for the training and the community organization, Fairbanks Wellness Coalition (FWC). FWC requested the development of this training. The photograph is a gentle reminder of the "Home" page from the Canvas Infrastructure platform where the developer expounded on the importance of the photograph for the community of Fairbanks, AK. Two students from the graduating class of 2018 died by suicide that school year.

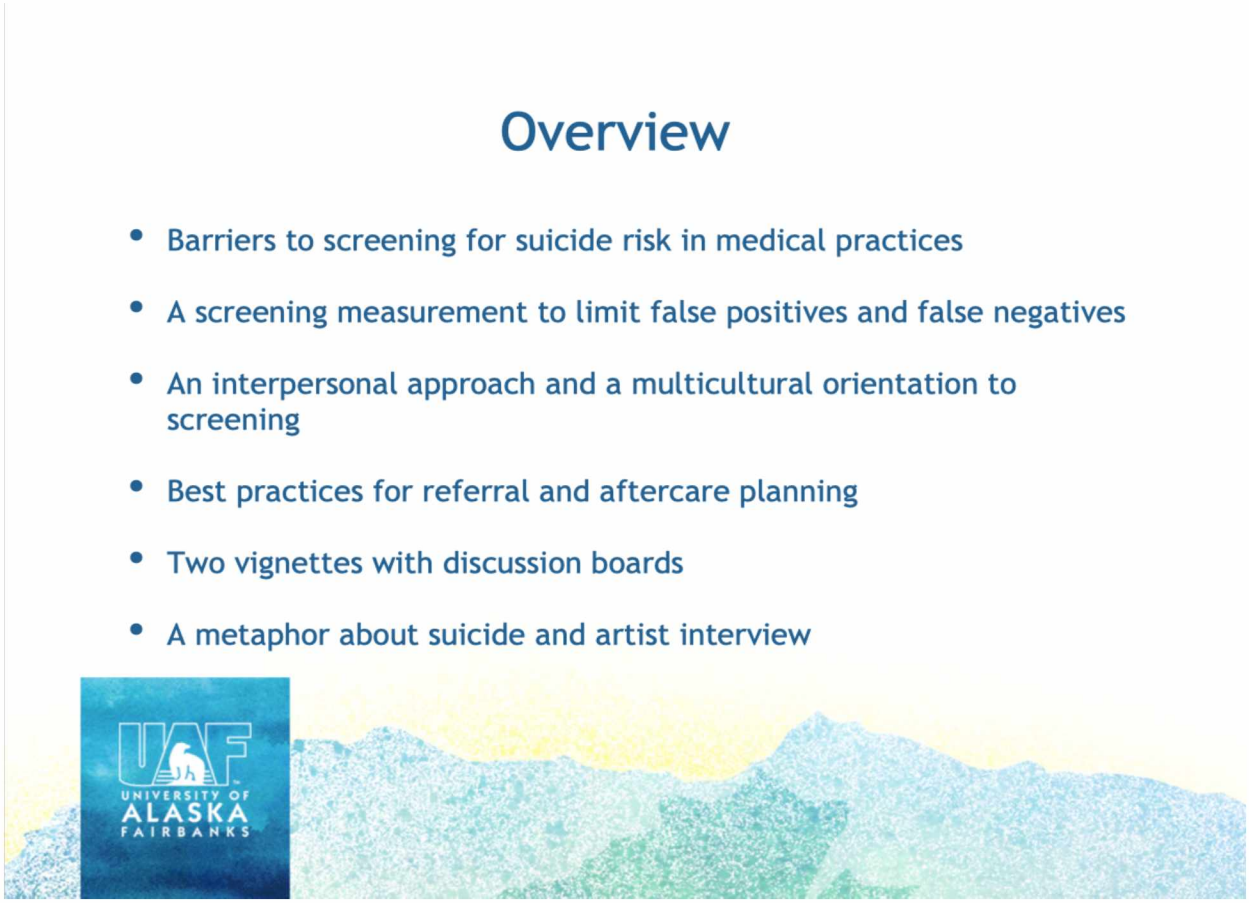
Slide two, "Creating a Localized Training Program for our Medical Providers," comprises of statistics of local, state, and national deaths by suicide. The developer includes a comparison of state and national statistics of deaths by suicide to highlight the importance of a local training program for medical providers.



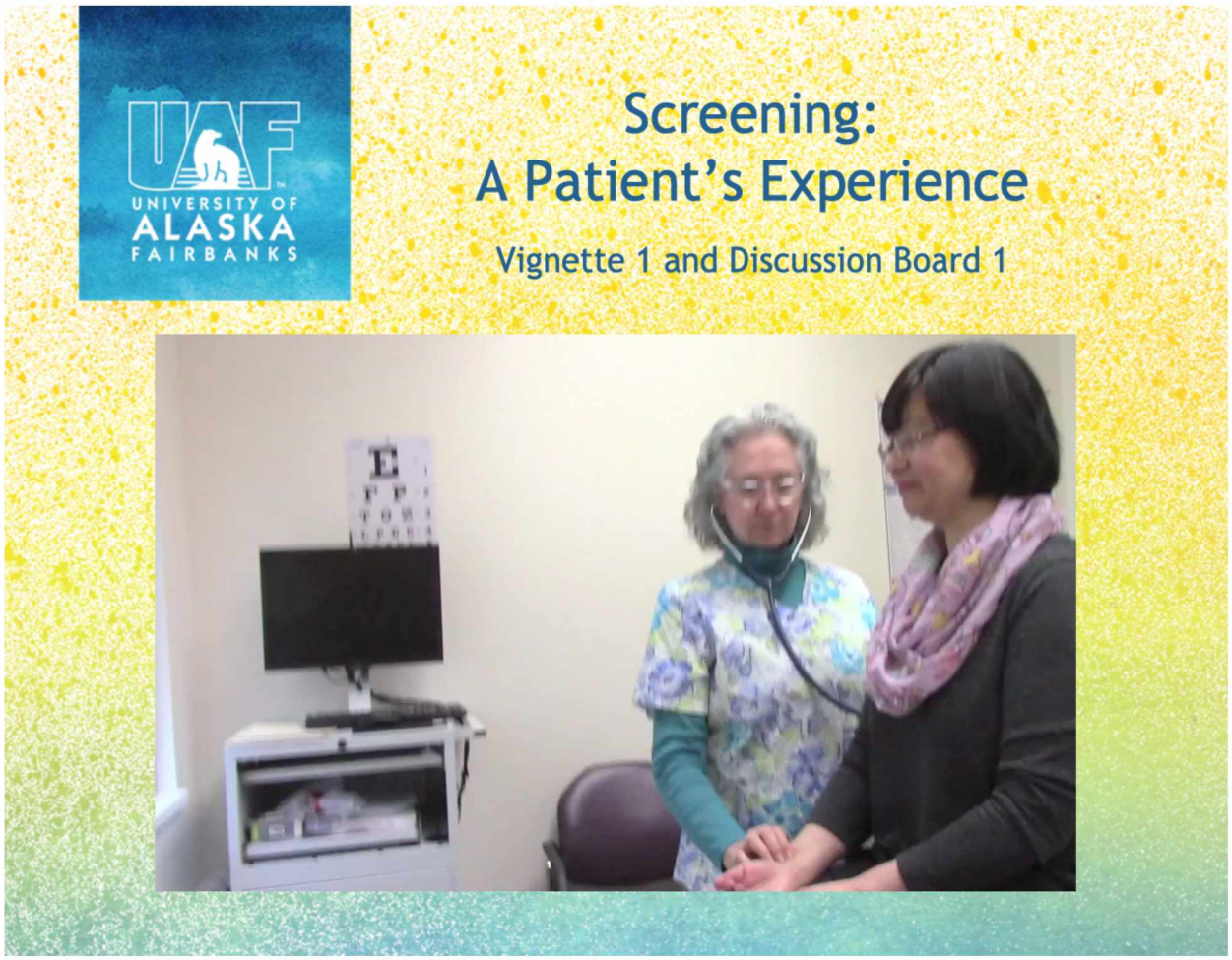
Slide three is titled "Screening in Primary Care Practices" and demonstrates the premise that medical providers are in a unique position to screen for suicide risk in patients. Presenters approach the audience with facts and encouragement when reporting the statistics of patients who visited medical providers before dying by suicide.



Slide four, "Overview," is an agenda for the webinar. Since there are several parts for the presentation on Canvas, it was important to provide a cohesive outline and list the objectives of the content from the three webinar modules.

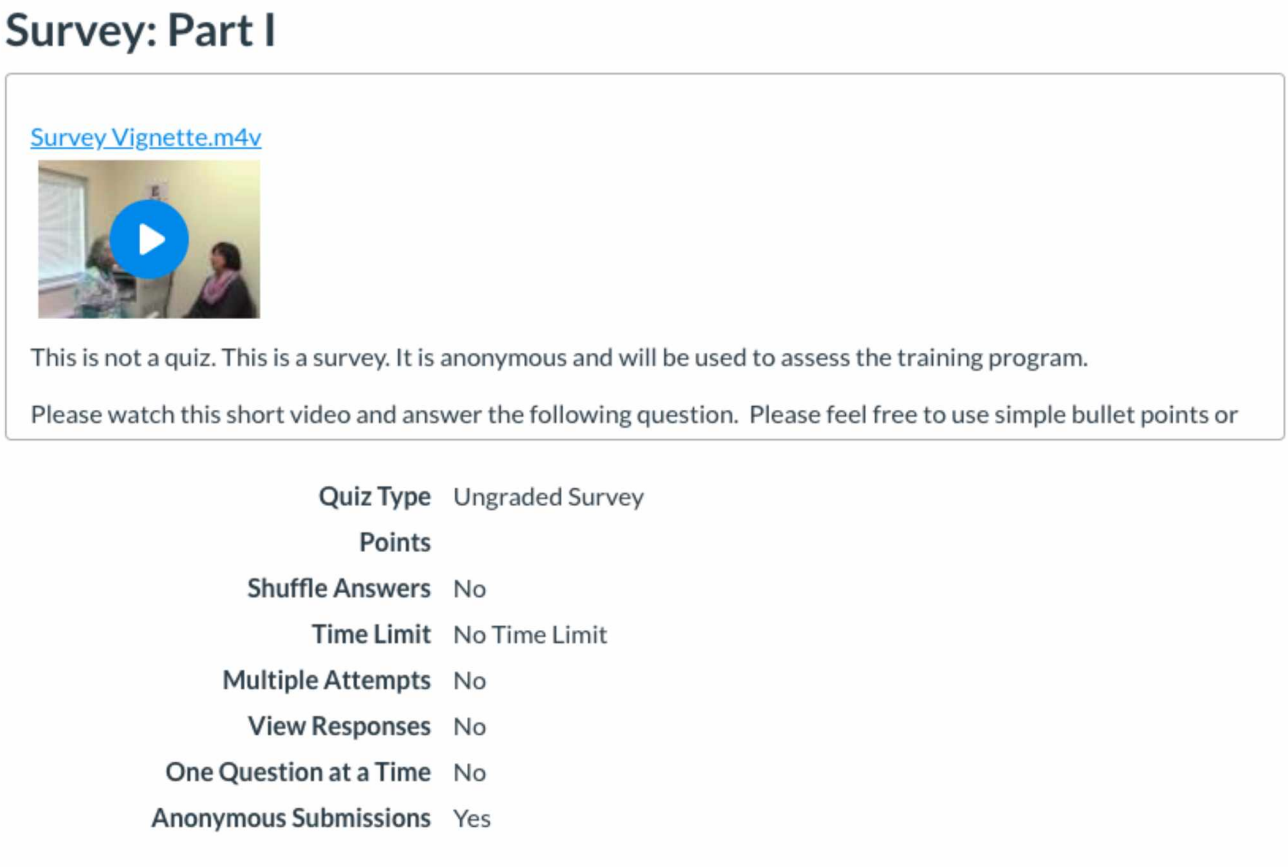


Slide five, "Screening: A Patient's Experience," is an introduction to video vignette one. Video vignette one is a short vignette of a typical experience of screening for suicide risk in medical settings. After the introduction to video vignette one, medical providers click on Survey: Part I to watch the video vignette, participate in a survey, and participate in a discussion board.



Survey: Part I

Survey: Part I is the second module of the webinar and includes the video vignette, survey form, and discussion board. The video vignette is an example of a typical experience during an ineffective suicide risk screening. Once the vignette is completed, medical providers have an opportunity to express their thoughts about the video vignette and apply their current knowledge about suicide risk. The survey form is a single question focusing on how medical providers assign the patient in the vignette at low, medium, or high risk of suicide. There is a link to a PDF color-coded chart from The Columbia Lighthouse Project (2018) defining low, medium, and high risk of dying by suicide. The Columbia Lighthouse Project is the website for the C-SSRS. Medical providers choose a level of risk of dying by suicide and explain how they decided the risk level. This survey offers time for the medical provider to evaluate what they already know about suicide risk before starting Webinar Presentation: Part II. Discussion Board I was created as part of Survey: Part I. The discussion board is optional and allows a medical provider time to process how they reacted to video vignette one.



Question 1 0 pts

1. What level of risk would you assign this patient? Explain why you chose this level of risk for the patient. Please use this form when answering question 5 for low risk (color-coded yellow), medium risk (color-coded orange), and high risk (color-coded red): Community-Card-Patients-2018c.pdf

2. Can you identify any risk factors for this patient?

3. Can you identify any interpersonal techniques the nurse used with this patient?

4. Can you identify any cultural aspects the nurse considered for this patient?

5. Were there any theoretical approaches or frameworks you noticed?

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12pt Paragraph

ASK YOUR PATIENTS
CARE FOR YOUR PATIENTS
ESCORT YOUR PATIENTS

THE COLUMBIA LIGHTHOUSE PROJECT

See Reverse for Questions that Can Save a Life

	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, answer questions 3, 4, 5 and 6 If **NO** to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	**Lifetime**	**Past 3 Months**
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

NATIONAL SUICIDE PREVENTION LIFELINE
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Any YES requires a behavioral health referral. If the answer to 4, 5 or 6 is YES, immediately ESCORT to Emergency Personnel for further evaluation.

DON'T LEAVE THE PERSON ALONE. STAY WITH THEM UNTIL THEY ARE IN THE CARE OF PROFESSIONAL HELP

Discussion Board I

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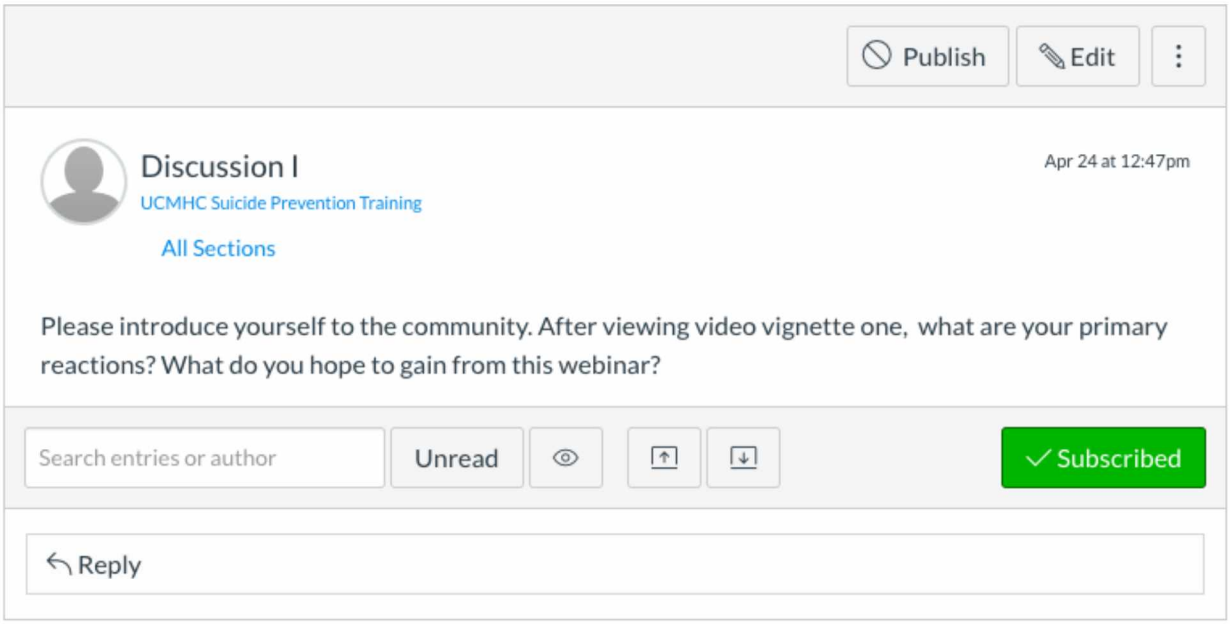
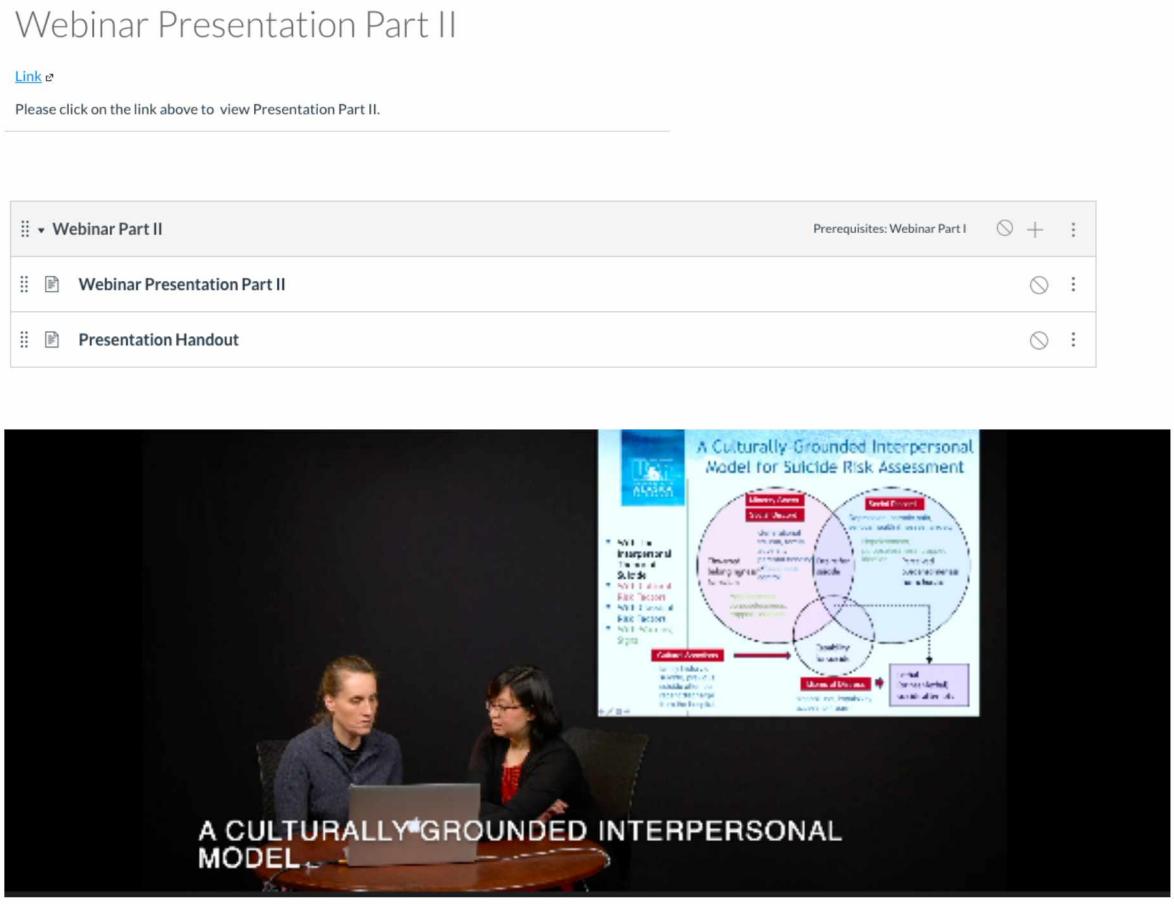


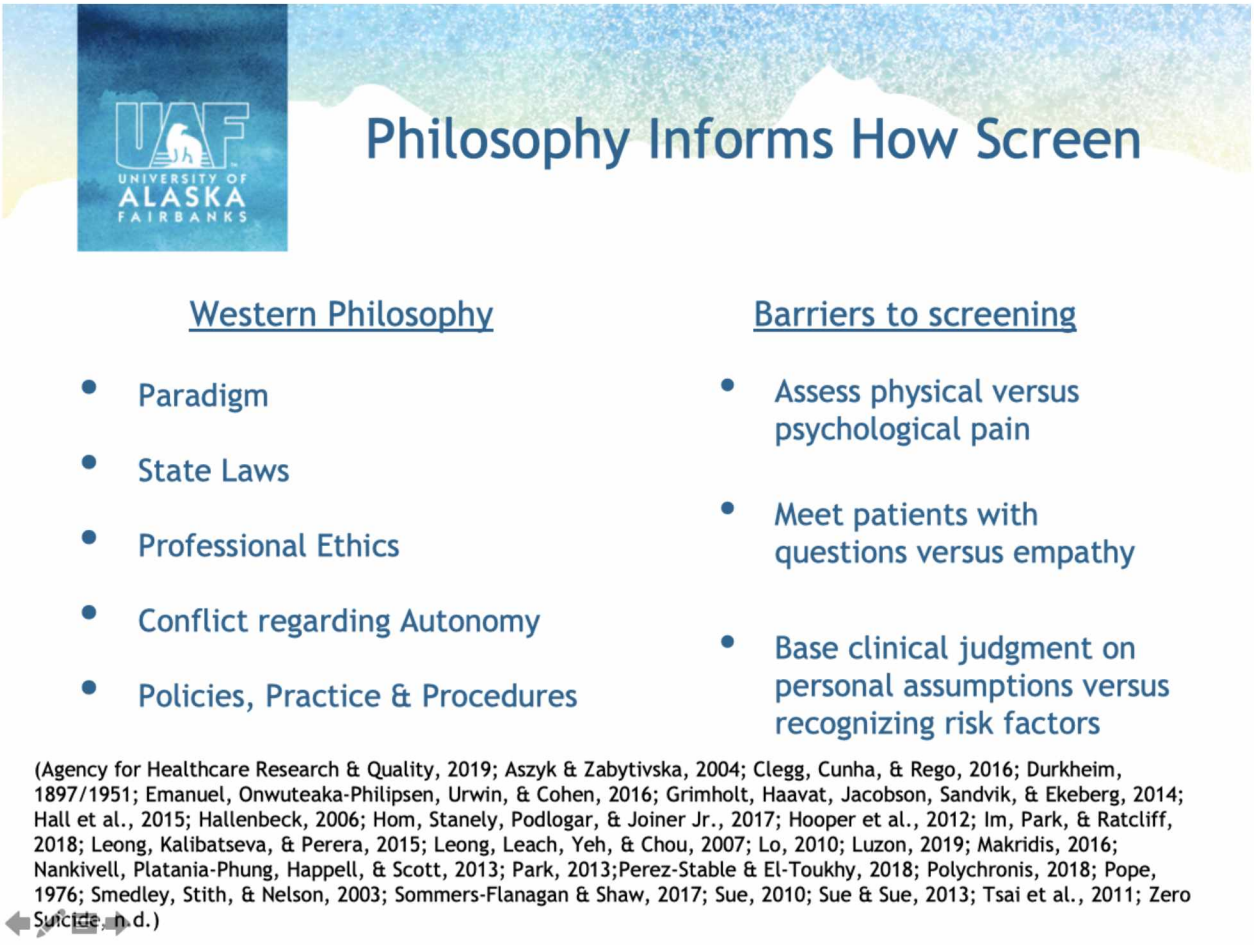
Webinar: Part II

Webinar: Part II consists of the second part of the presentation. Two handouts are provided to assist medical providers with understanding the content. The second part of the presentation focuses on the bulk of the content for the webinar. Presenters discuss slides 6-16, beginning with an explanation how philosophy influences the ways in which medical providers screen for suicide. This supports the next topic, regarding the C-SSRS and the importance of clinical judgment. A discussion about Joiner's (2005) interpersonal theory of suicide follows the C-SSRS because it is the foundation to the development of the C-SSRS and the framework for C-GIMS. Chu and colleague's (2010) cultural model of suicide follows the topic of Joiner's interpersonal theory of suicide since the cultural model was not included in the development of the C-SSRS and is incorporated into C-GIMS. Next, how the C-GIMS embraces classical risk factors, cultural risk factors, and warning signs into the interpersonal theory of suicide and cultural model of suicide is explained by the presenters. Protective factors are influenced by culture. An individualized approach to screening for suicide risk focuses on interpersonal and cross-cultural communication. The second handout are example questions of an interpersonal and culturally-attuned modification using the original questions from the C-SSRS. The next section lists questions a medical provider can ask themselves to support their conceptualization of a patient's risk of dying by suicide. Lastly, there is an introduction to vignette two.

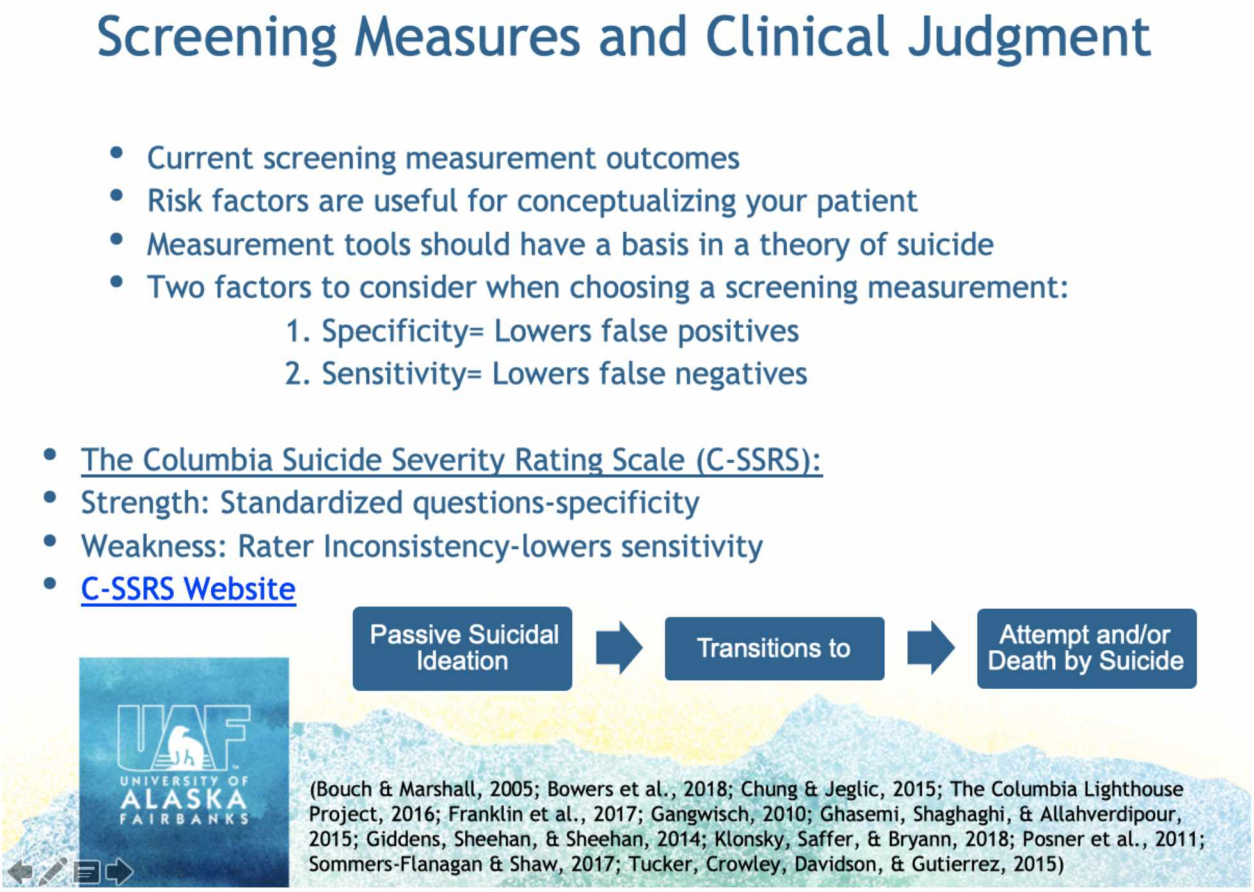


Webinar Part II: PowerPoint Presentation, Slides 6-16

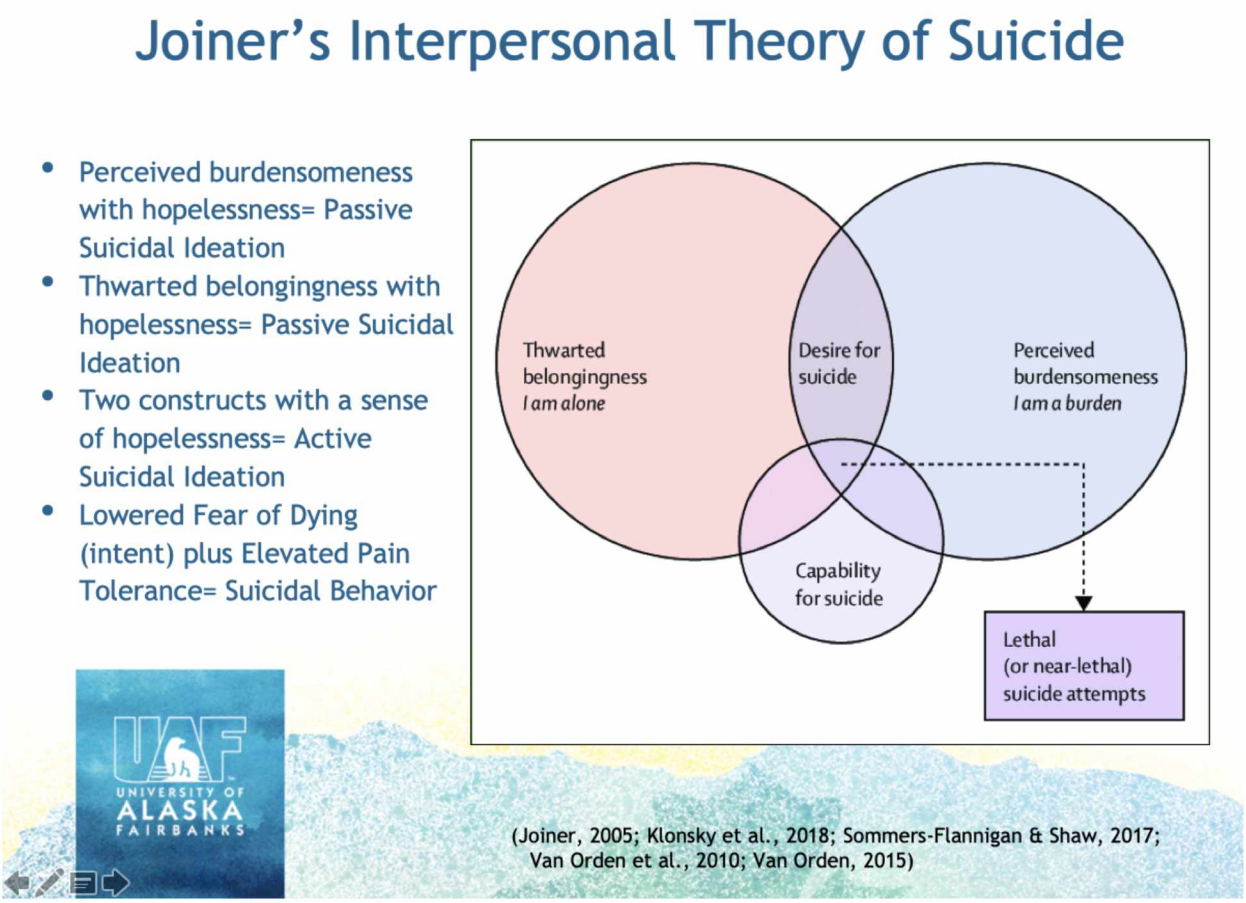
The first slide of Part II is slide number six, "Philosophy Informs How and if We Screen for Suicide." If a medical provider is aware of their personal philosophy about suicide, then they can acknowledge the differences of a patient's worldview compared to their own worldview. This slide is for medical providers who screen for suicide to consider improving self-awareness.



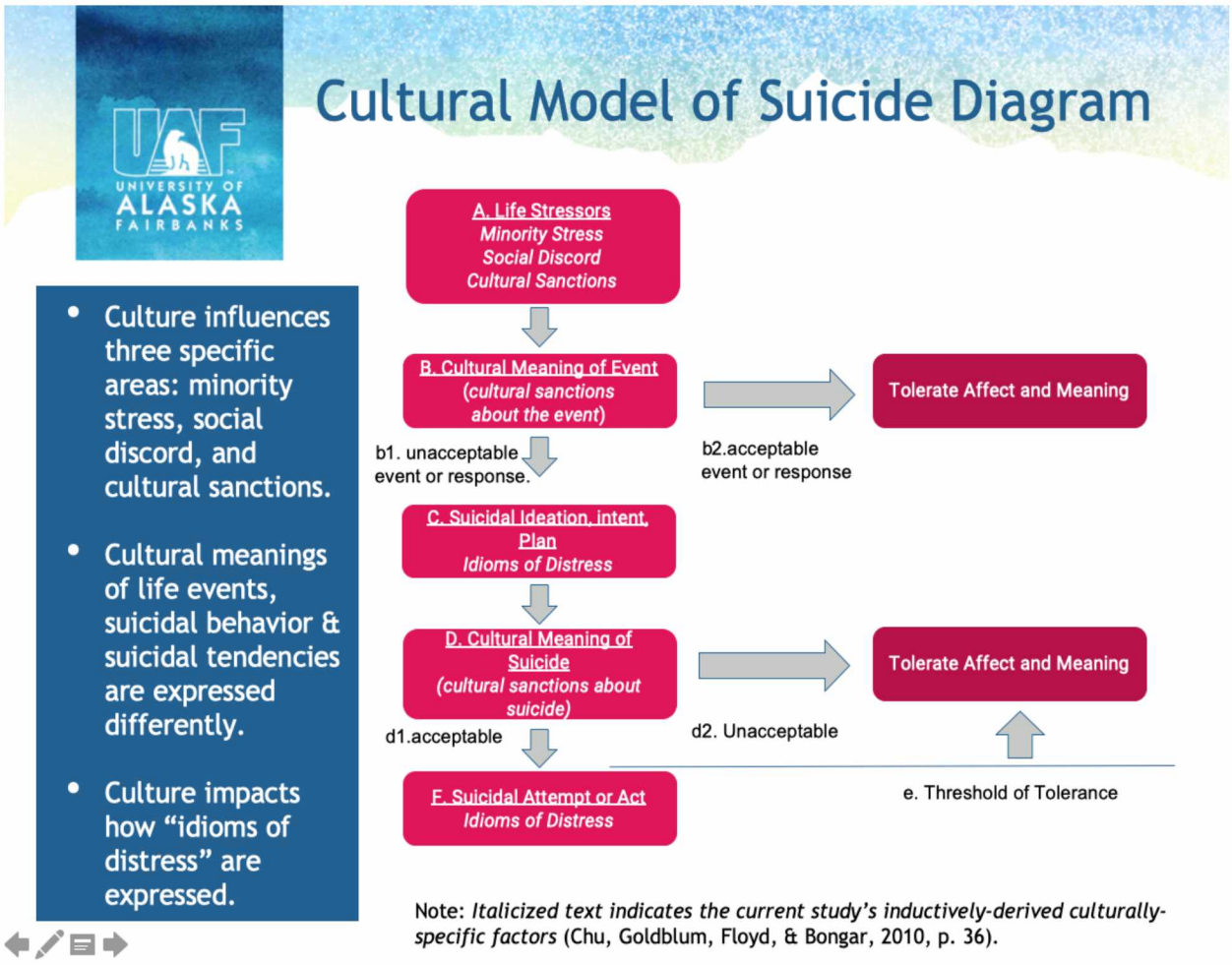
In the next slide, "Screening Measures and Clinical Judgment," presenters delineate the aspects to choosing a screening measurement, the development of the C-SSRS, and the advantages and disadvantages of the C-SSRS. Then, presenters navigate to the website https://cssrs.columbia.edu/ using the link "C-SSRS Website." There are a number of versions of the C-SSRS available without a fee.



The next section of Part II connects each piece of C-GIMS. For slide eight, Joiner's interpersonal theory of suicide is the framework for the C-GIMS and a foundation for the C-SSRS. "Joiner's Interpersonal Theory of suicide," begins expounding the content that led to the creation of C-GIMS. The first part of C-GIMS are Joiner's interpersonal theory of suicide (Joiner, 2005) and the cultural model of suicide (Chu et al., 2010). The interpersonal theory of suicide and cultural model of suicide are detailed separately, then demonstrated together in another slide, "The Culturally-Grounded Interpersonal Model for Suicide Risk Assessment (Part I)." "The Culturally-Grounded Interpersonal Model for Suicide Risk Assessment (Part II)" combined classical risk factors, cultural risk factors, and warning signs into the diagram from "The Culturally-Grounded Interpersonal Model for Suicide Risk Assessment (Part I)."

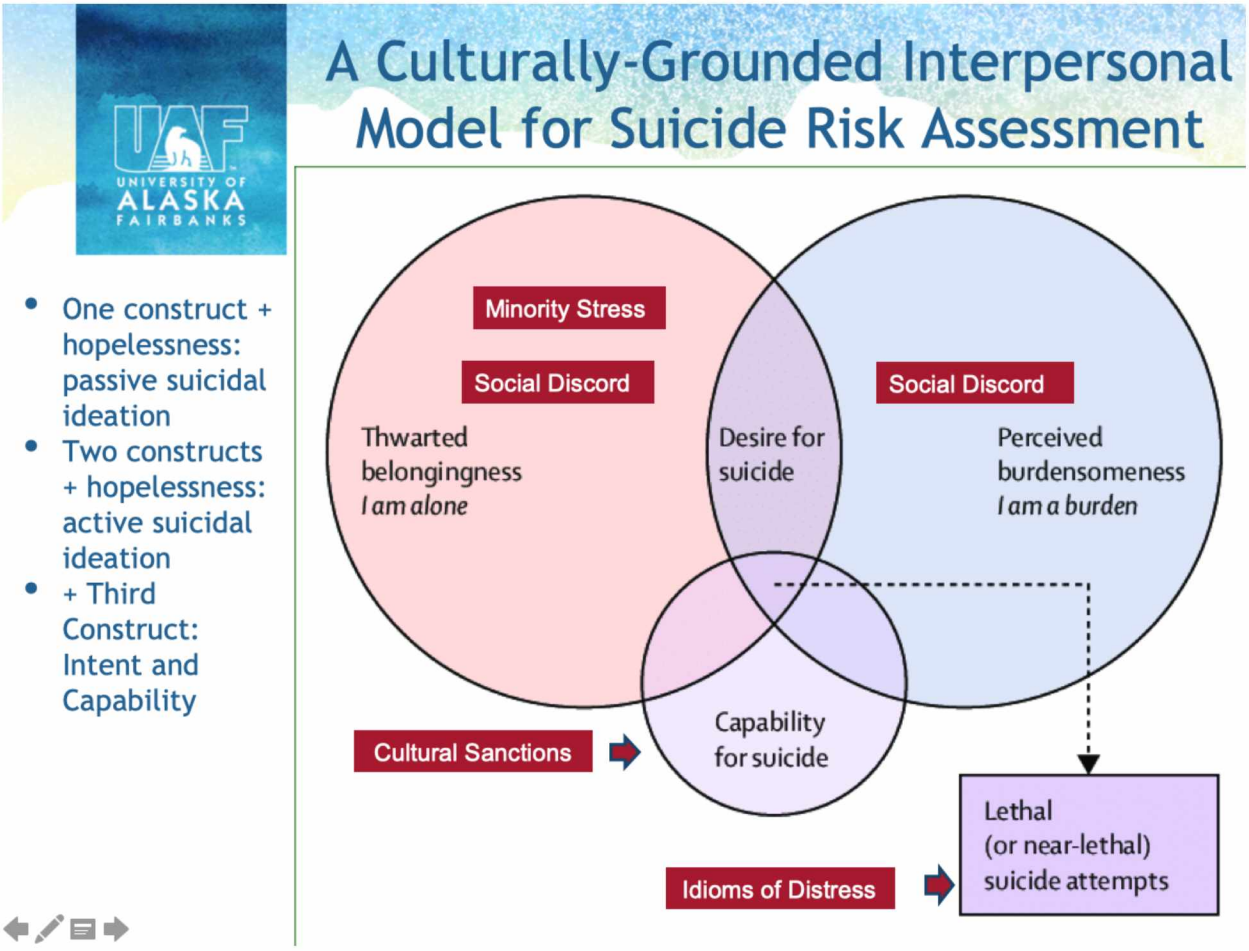


Slide nine, the "Cultural Model of Suicide Diagram," is the second piece of C-GIMS. Chu and colleagues (2010) introduced cultural risk factors, but did not connect the model and cultural risk factors to Joiner's interpersonal model of suicide. This model was not included in the development of the C-SSRS. The presenters explain the cultural model of suicide and how life stressors, social discord, cultural sanctions about suicide, and idioms of distress (expression of suicidal ideation) are culturally influenced.



Note: *Italicized text indicates the current study's inductively-derived culturally-specific factors* (Chu, Goldblum, Floyd, & Bongar, 2010, p. 36).

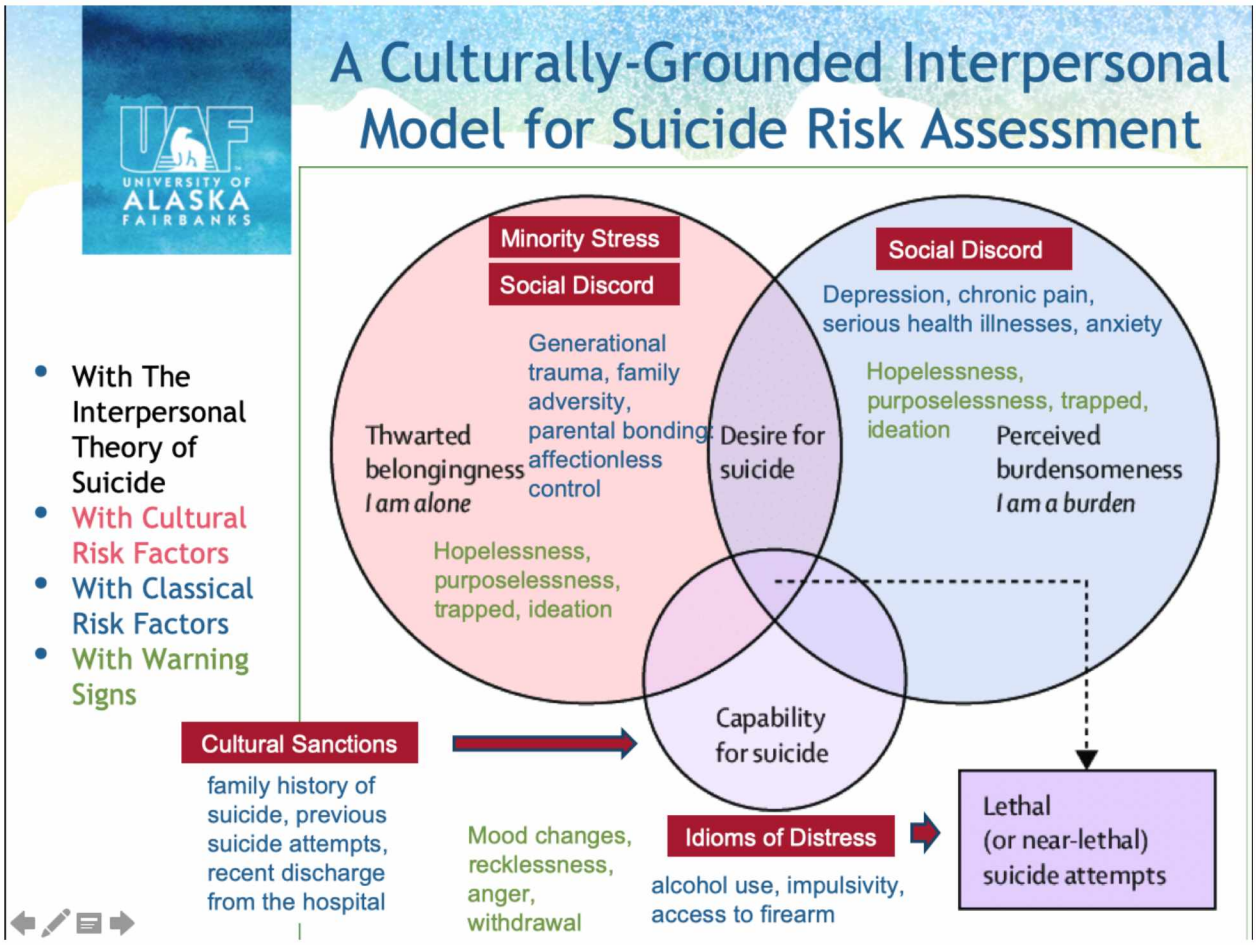
"A Culturally-Grounded Interpersonal Model for Suicide Risk Assessment (Part I)" is slide ten. It depicts how the C-GIMS incorporates Joiner's (2005) interpersonal theory of suicide with the cultural model of suicide (Chu et al., 2010). The presenters offer an example of a young man transitioning from a rural high school to the University of Alaska Fairbanks to illustrate how the model works.



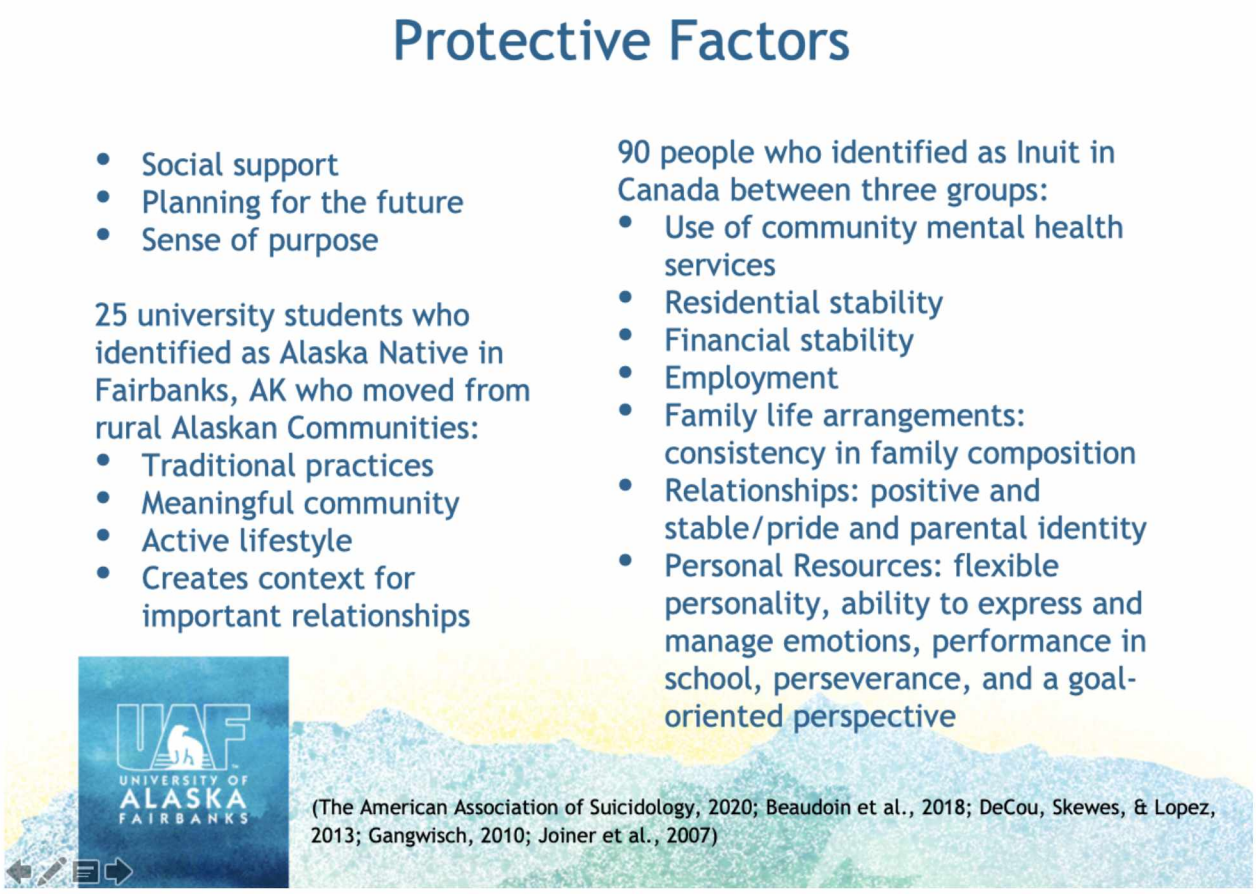
Next, presenters review the "Cultural and Classical Risk Factors" slide. The cultural risk factors are explained with more detail. Additional cultural aspects to consider were addressed, including hidden ideation and protective factors. Affectionless control is explained using the example of a child who has parent(s) with a high level of control and low level of affection. Warning signs are introduced verbally using the "Is Path Warm" mnemonic.

I	Ideation
S	Substance Use (increased/excessive)
P	Purposelessness
A	Anxiety
T	Trapped
H	Hopelessness
W	Withdrawal
A	Anger
R	Recklessness
M	Mood Changes

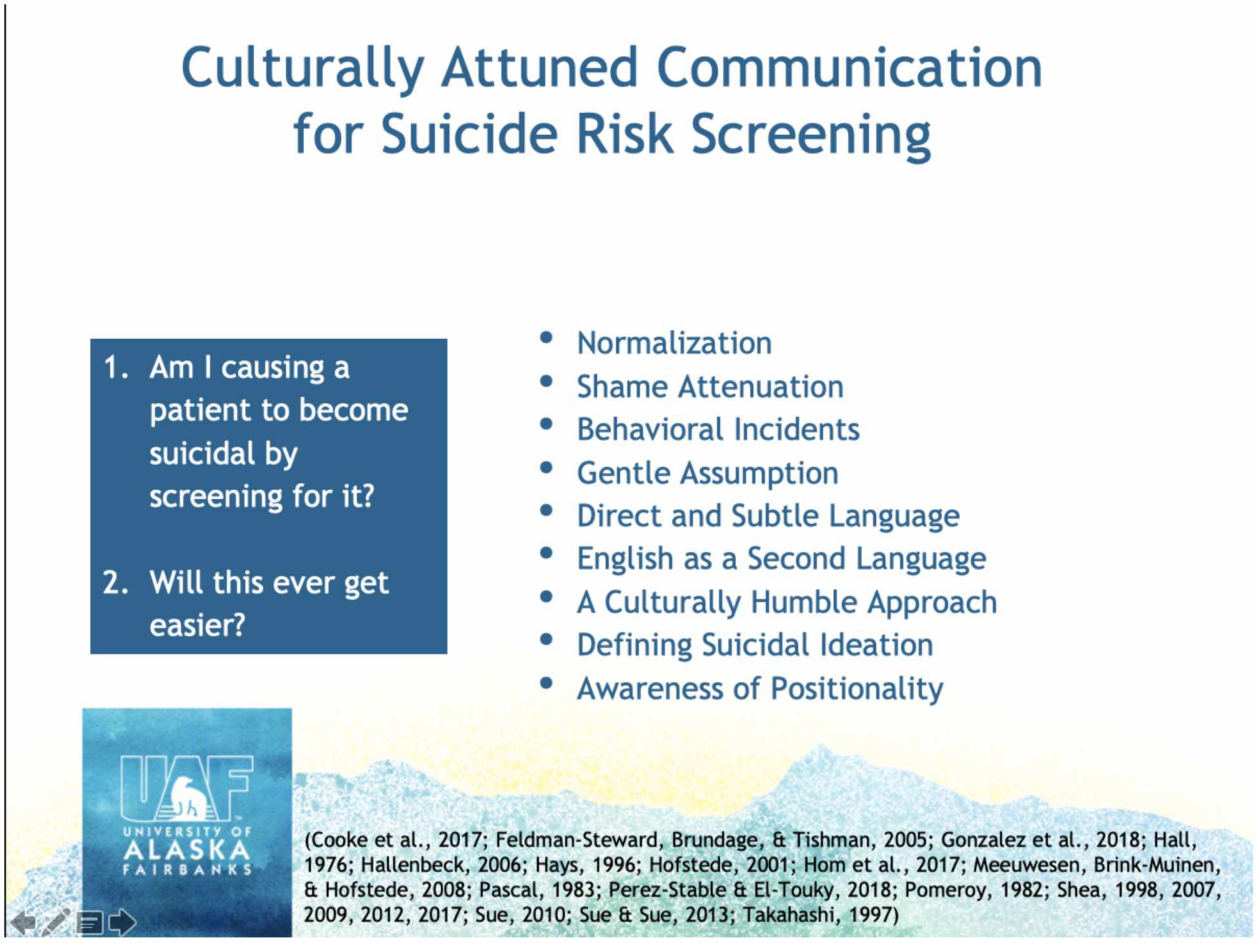
Slide number 12 is titled "A Culturally-Grounded Interpersonal Model for Suicide Risk Assessment" and is part II of the model demonstration. The presenters use this slide to incorporate classical risk factors, cultural risk factors, and warning signs from part I of "A Culturally-Grounded Interpersonal Model for Suicide Risk Assessment" slide. The diagram is color-coded with a key to represent the different elements of the C-GIMS. The presenters continue using the example of a young man transitioning from a rural high school to the University of Alaska Fairbanks to illustrate how the model works to improve understanding a patient's experience of suicidal ideation.



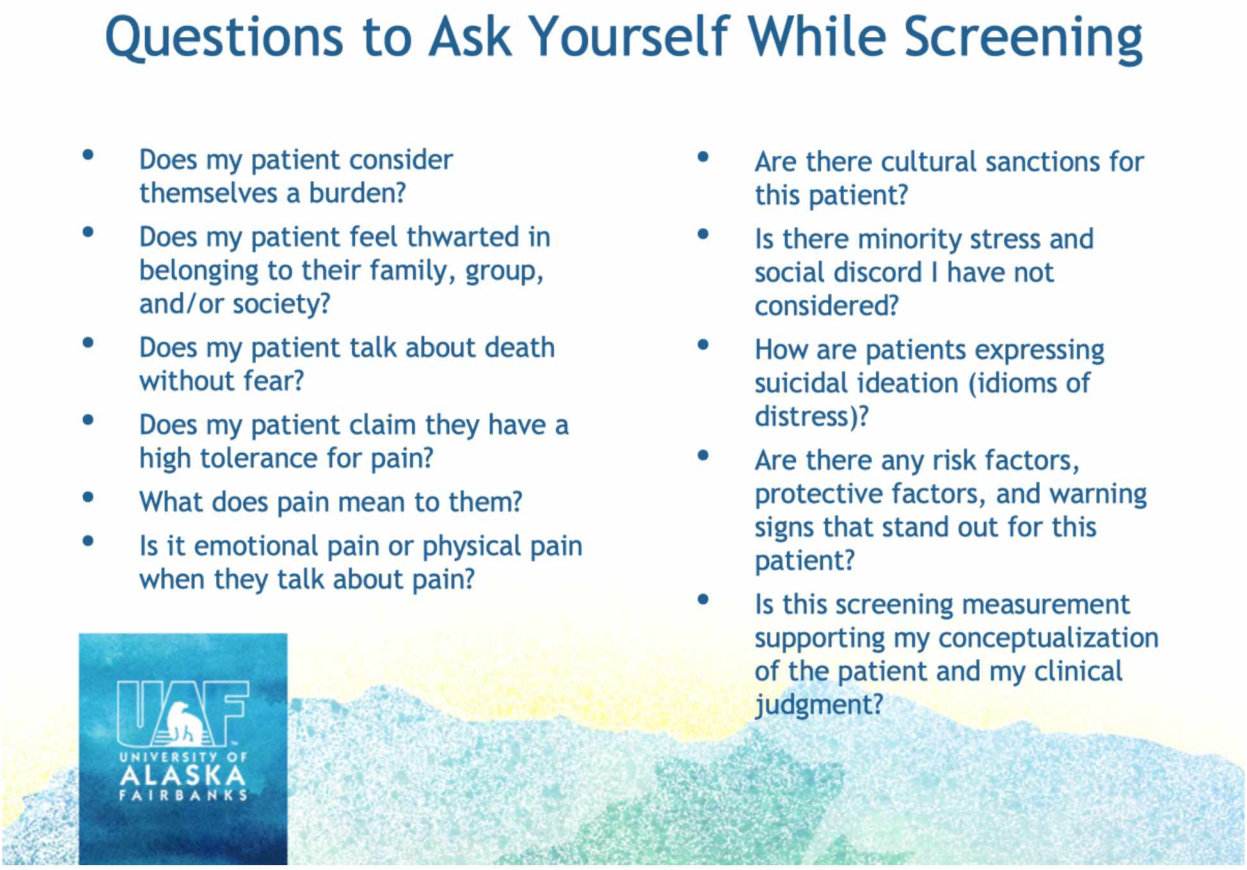
Slide 13, "Protective Factors," alert medical providers to how a protective factor does not cancel out a risk factor, but rather aids in understanding a patient's experience of suicidal ideation. Presenters were sure to delineate how protective factors may be culturally-influenced (DeCou et al., 2013; Beaudoin et al., 2018). Protective factors for people who identified as AN/IN were included in this slide. The presenters continue using the example of a young man transitioning from a rural high school to the University of Alaska Fairbanks to illustrate how protective factors are influenced by culture.



In slide 14, "Culturally Attuned Communication for Suicide Risk Screening," the presenters listed several techniques relevant to screening for suicide risk, including the CASE approach, which improves the validity of screening patients at risk of dying by suicide. The CASE approach can be used for a structured assessment like the C-SSRS (Shea, 2012). Challenging barriers to quality care—such as language barriers, fear of authorities, and defining the term suicidal ideation—helps to improve screening patients for suicide risk.



Slide 15, "Questions to Ask Yourself While Screening," is a concrete way for medical providers to consider the theoretical underpinnings of G-CIMS and to practice self-awareness.

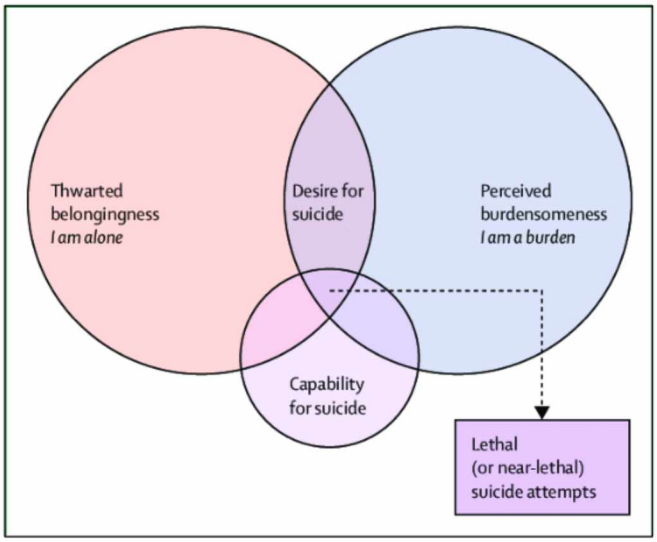


In slide 16, "Screening: An Interpersonal Approach," the presenters introduce video vignette two, which depicts a screening for suicide risk by a medical provider using the knowledge gained from Webinar Part II.

Presentation Handout I

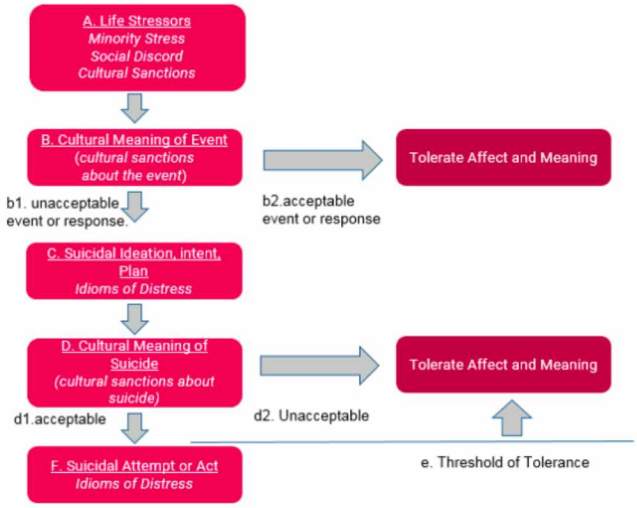
The presentation handout was created to assist medical providers through the Webinar Presentation: Part II in Canvas. Medical providers can use this handout as a visual learning tool for the interpersonal theory of suicide (Joiner, 2005), the cultural model of suicide (Chu et al., 2010), and C-GIMS.

Joiner's Interpersonal Theory of Suicide



- Perceived burdensomeness with hopelessness= Passive Suicidal Ideation
- Thwarted belongingness with hopelessness= Passive Suicidal Ideation
- Two constructs with a sense of hopelessness= Active Suicidal Ideation
- Lowered Fear of Dying (intent) plus Elevated Pain Tolerance= Suicidal Behavior

Cultural Model of Suicide



Note: *Italicized text indicates the current study's inductively-derived culturally-specific factors* (Chu, Goldblum, Floyd, & Bongar, 2010, p. 36).

Cultural Specific Risk Factors gathered from a twenty-year analysis (1991-2011) with people who identified as African-American, Asian-American, Latino-American, and the LGBTQ groups:

- Cultural Sanctions
- Idioms of Distress
- Minority Stress
- Social Discord
- Additional Cultural Aspects:
- Hidden Ideation
- Protective Factors

Classical Risk Factors:

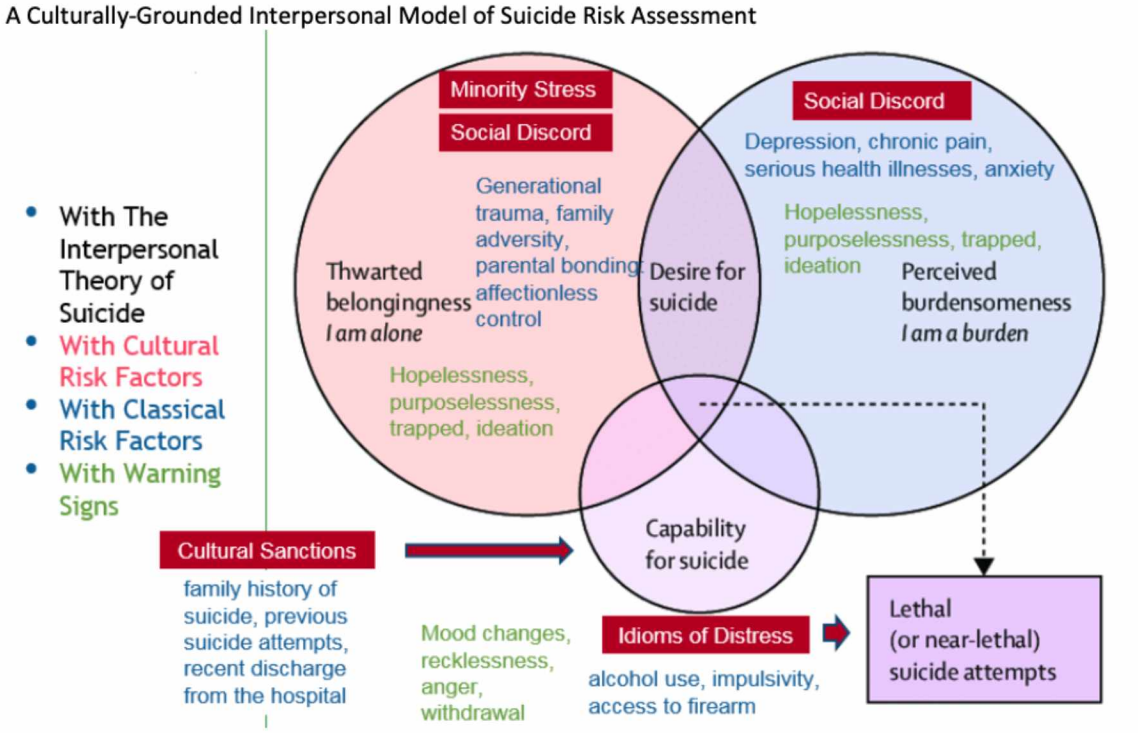
- Depression
- Alcohol/Substance Use Disorder
- Impulsivity
- Chronic pain
- Serious health illnesses
- Anxiety
- Family adversity
- Parental Bonding: Affectionless control
- Previous suicide attempts
- Family history of suicide
- Recent discharge from hospital or treatment center
- Access to a firearm

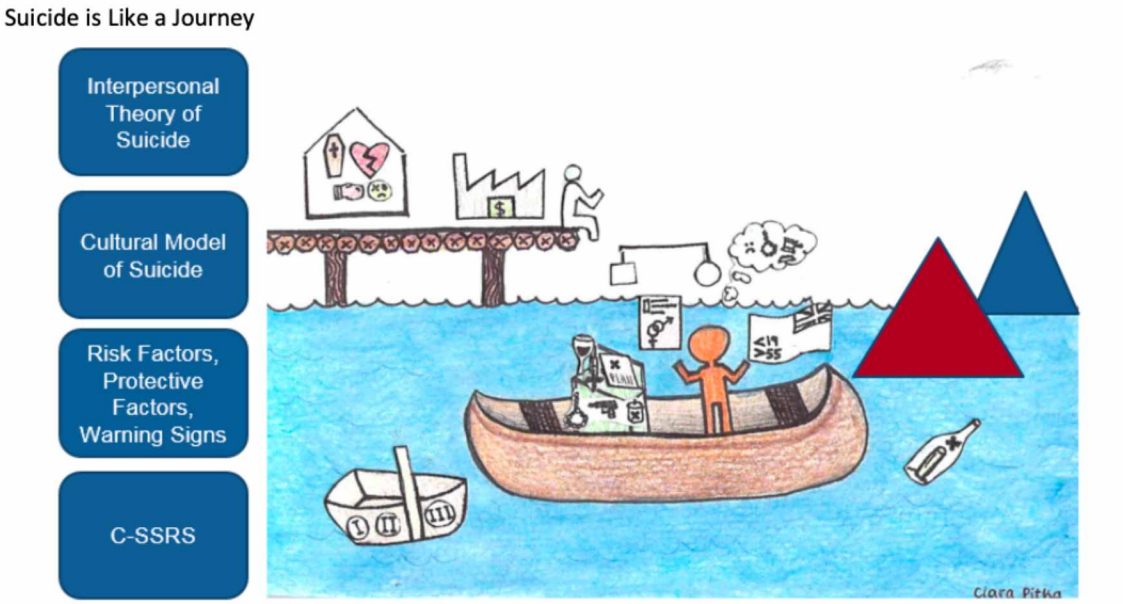
Warning Signs

I Ideation
S Substance abuse

P Purposelessness
A Anxiety
T Trapped
H Hopelessness

W Withdrawal
A Anger
R Recklessness
M Mood Changes





(Alyami et al., 2016, American Foundation for Suicide Prevention, 2018, American Association of Suicidology, 2107, Bouch & Marshall, 2005, Cooke et al., 2013, Goschin, et al., 2013, Hooper et al., 2012, King et al., 2008, Kovess-Masfety et al., 2011, Pitka, 2017)

The blue and red triangles represent the journey's distance toward "suicide." The blue triangle illustrated the journey of a person who identifies with a culture that have sanctions against suicide. The red triangle illustrated the journey of a person who identifies with a culture that does not have cultural sanctions against suicide.

Presentation Handout Two

The second handout was created to assist medical providers with incorporating the interview techniques from the slide "Culturally Attuned Communication for Suicide Risk Screening." This handout was created to offer another concrete approach to screening for suicide risk. In feedback from previous in-person presentations of this webinar, medical providers implied that abstract theories needed to be operationalized. The original questions from the C-SSRS screening were modified to reflect an individualized, interpersonal, and culturally-attuned approach to communication when screening for suicide risk. In parenthesis, the developer labeled the different techniques used to modify the standard C-SSRS questions.

Culturally Attuned Communication Using the Columbia-Suicide Severity Rating Scale

1)It's not unusual for people who are feeling miserable to think about suicide. Have you had any thoughts about suicide (NORMALIZE)?

2) "Some people with cancer have thoughts of killing themselves; this may be happening for you. I can help you and you don't have to suffer alone" (NORMALIZE and GENTLE ASSUMPTION).

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

3)With all of your pain, have you been thinking of how you may do this (SHAME ATTENUATION)?

4)"I wonder if" you had these thoughts and some intention of acting on them (CULTURALLY HUMBLE APPROACH)?

5)A patient you have seen before has a fresh scar or scab on their wrist, you could ask, "Did you put a razor blade up to your wrist?" when a patient comes needing stitches on their wrist. Sequential questioning can easily be used with the question, "Then what happened" (BEHAVIORAL INCIDENTS)?

6)Gentle assumption: when was the last time you started to do anything or prepared to do anything to end your life (GENTLE ASSUMPTION)?

If YES, ask: Was this within the past 3 months?

Survey: Part II

For the Survey: Part II module, there are three pieces: a second short vignette depicting a screening for suicide risk by a medical provider, a survey question, and a discussion board. Survey: Part II has a post-training video vignette depicting a patient's experience with a provider who uses C-GIMS and an individualized approach to screening for suicide risk. Once the vignette is viewed, medical providers have an opportunity to express their thoughts about the video vignette and apply their knowledge gained from this webinar. The survey form is the same question from Survey: Part I. It is a single question focusing on how medical providers assign the patient in the vignette to low, medium, or high risk of suicide. There is a link to a PDF color-coded chart from The Columbia Lighthouse Project (2018) defining low, medium, and high risk of dying by suicide. The Columbia Lighthouse Project (2018) is the website for the C-SSRS. Explaining how the medical provider chooses a level of risk of dying by suicide offers time for the medical provider to implement the material they learned from Webinar Part II. Discussion Board II was created to go with Survey: Part II. Discussion Board II is optional and will allow time to process how medical providers reacted to the video vignette two.

Survey: Part II

Survey Vignette.m4v

This is not a quiz. This is a survey. It is anonymous and will be used to assess the training program. Please watch this short video and answer the following question. Please feel free to use simple bullet points or an essay format.

Quiz Type	Ungraded Survey
Points	
Shuffle Answers	No
Time Limit	No Time Limit
Multiple Attempts	Yes
Score to Keep	Highest
Attempts	Unlimited
View Responses	Always
Show Correct Answers	Immediately
One Question at a Time	No
Anonymous Submissions	Yes

Question 1 0 pts

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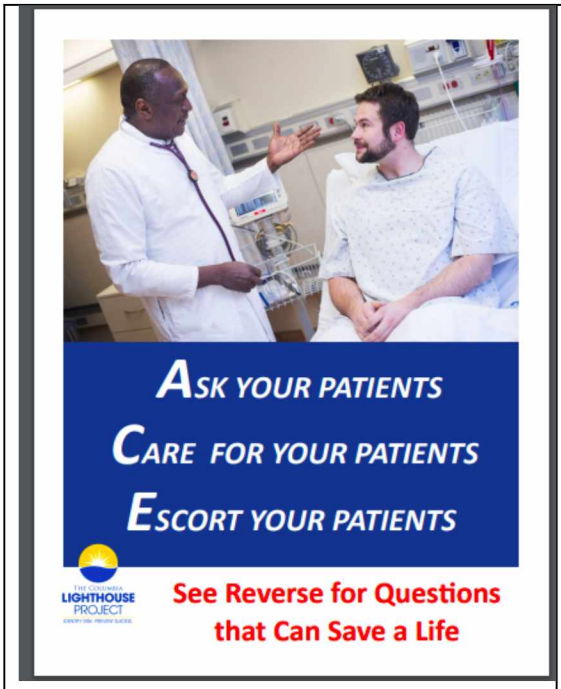

	Past Month
1) Have you wished you were dead or wished you could go to sleep and not wake up?	
2) Have you actually had any thoughts about killing yourself?	
If **YES** to 2, answer questions 3, 4, 5 and 6 If **NO** to 2, go directly to question 6	
3) Have you thought about how you might do this?	
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	High Risk
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	High Risk
Always Ask Question 6	Lifetime / Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.	High Risk

NATIONAL SUICIDE PREVENTION LIFELINE
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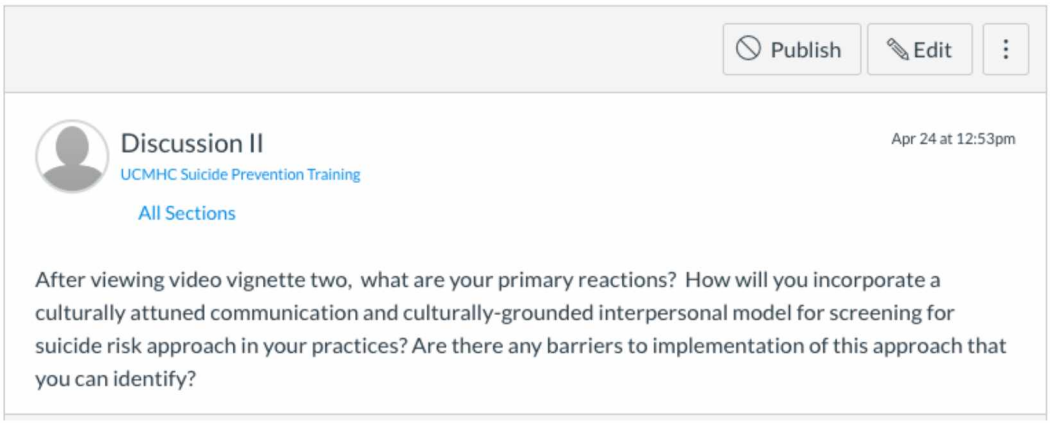


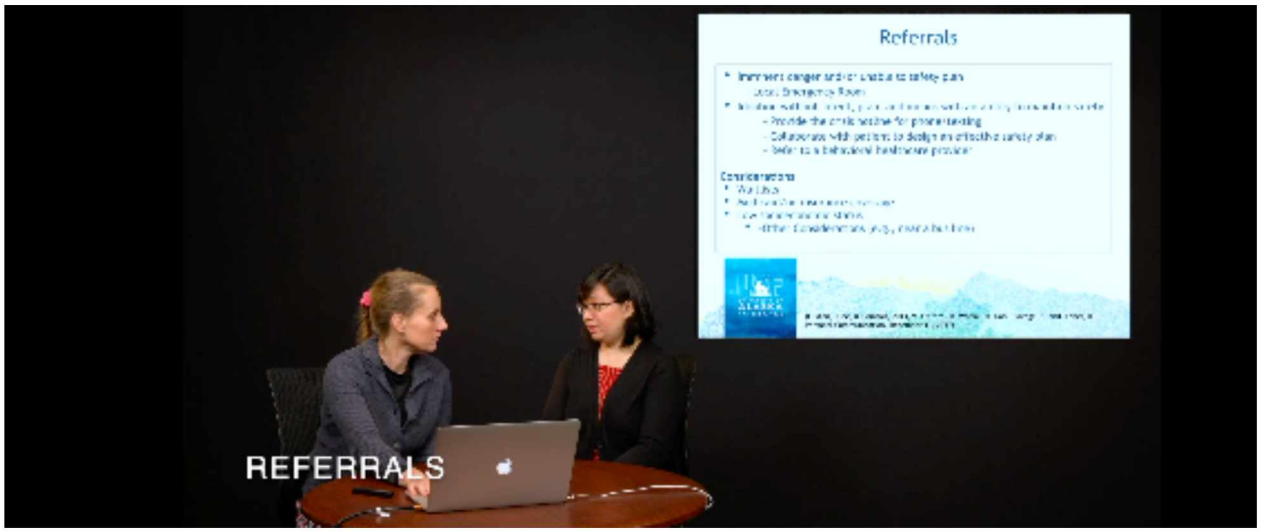
Webinar: Part III

Webinar: Part III consists of the third part of the presentation, artwork created by Ciara Pitka, and a video recording of an interview with the artist. The third part of the presentation (slides 17-31) consists of "Referrals," "Aftercare Planning," "Aftercare for Medical Providers," and "References." "Suicide is Like a Journey" is a metaphor that Ms. Pitka created to individualize a visual metaphor for the Fairbanks North Star Borough medical community. The module includes a link to a video of the artist revealing her motivation for supporting this webinar. In the module, there is a second link to download Ms. Pitka's original artwork.

Webinar Presentation III

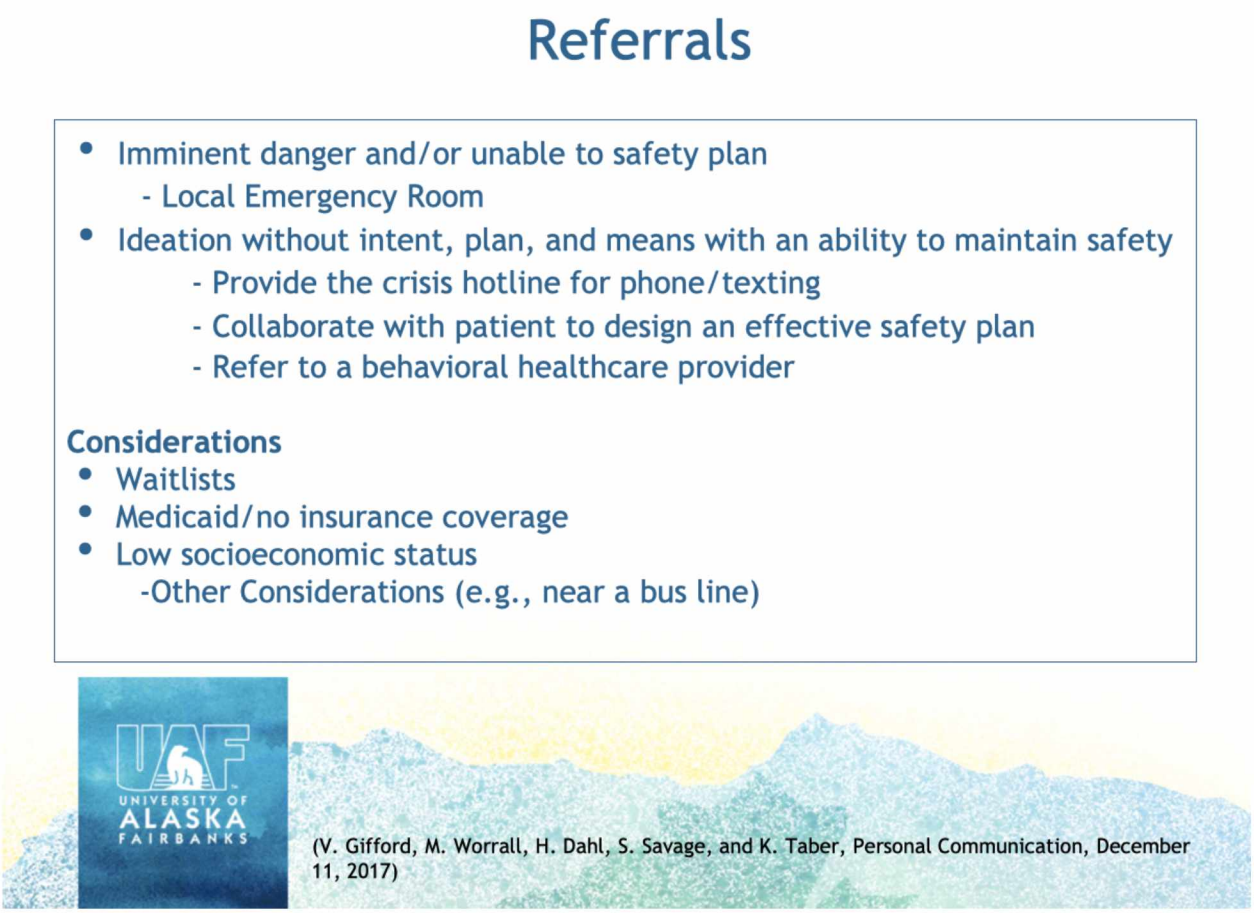
Link

Please click on the link above to view Presentation Part III.



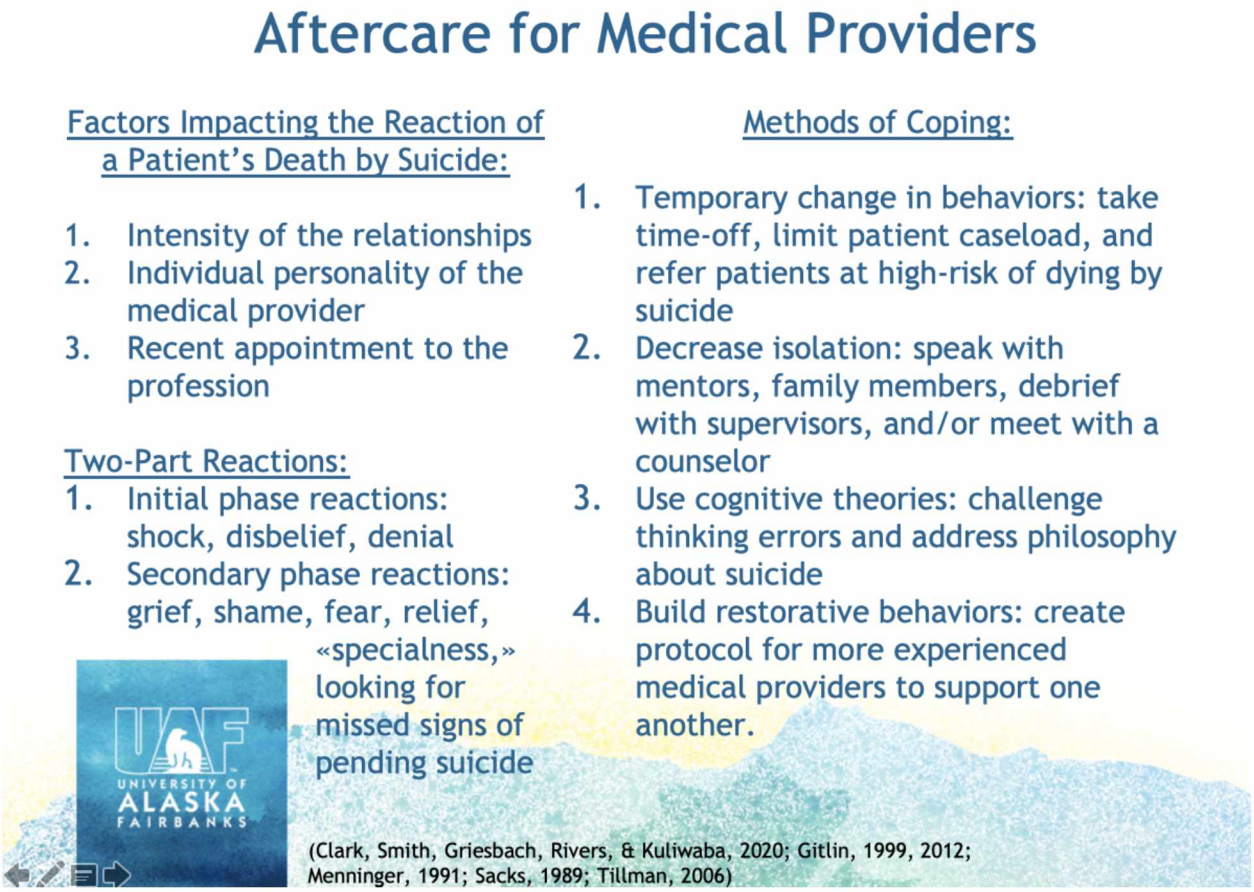
Webinar Part III: PowerPoint Presentation, slides 17-31

For slide 17, "Referrals," the presenters discuss follow up procedures for medical providers to know when to refer to a behavioral healthcare professional or to admit a patient to the Fairbanks Memorial Hospital. Considerations are highlighted for medical providers who may not be aware of the challenges patients may contend with to receive services.



The presenters use the "Aftercare Planning" slide to expound on the process of aftercare planning for patients and the important elements to include in an aftercare plan.

Presenters use slide 19, "Aftercare for Medical Providers," to describe common reactions for medical providers when a patient dies by suicide and to offer coping strategies. Examples of common reactions and an explanation of the meaning "specialness" are highlighted by the presenters. Different methods of coping to support medical providers in processing the death of a patient by suicide are addressed with concrete examples of each coping method.



References. "References" (slides 20-31) consist of the resources used by this author to create the presentation for the webinar.

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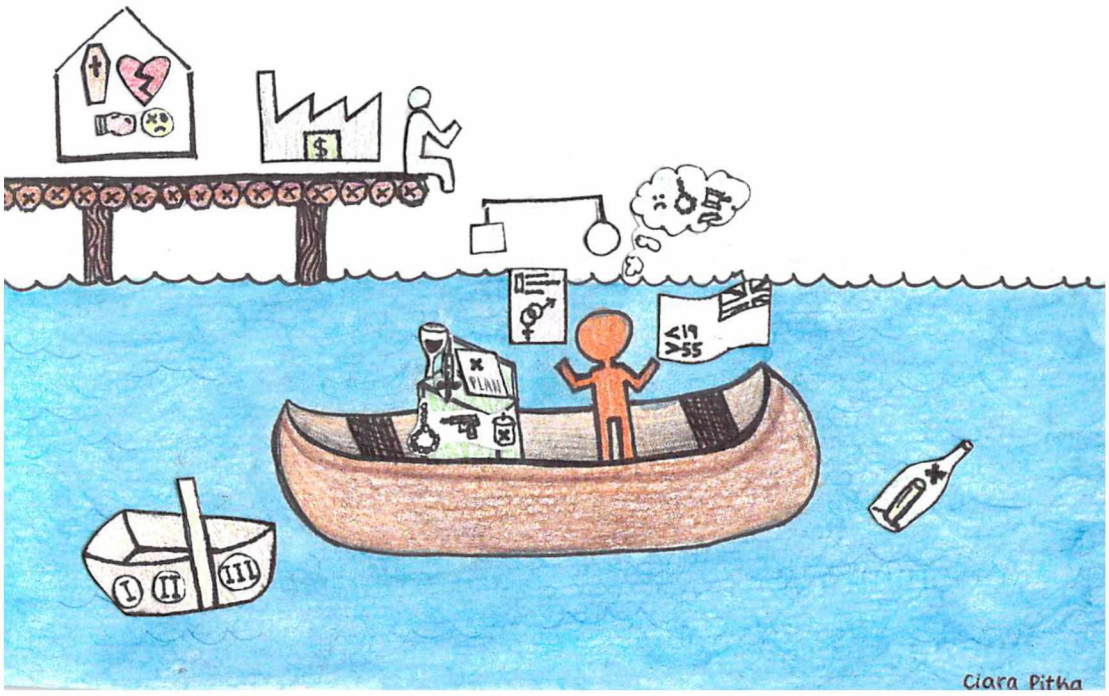
Artist Commentary: Ciara Pitka

A link from Webinar: Part III offers the audience an "Artist Commentary" interview where Ms. Pitka explains her motivation to support the webinar by creating a local piece of art, "Suicide is Like a Journey," a metaphor for suicide. Ms. Pitka changed objects within the metaphor to represent the Fairbanks North Star Borough community.

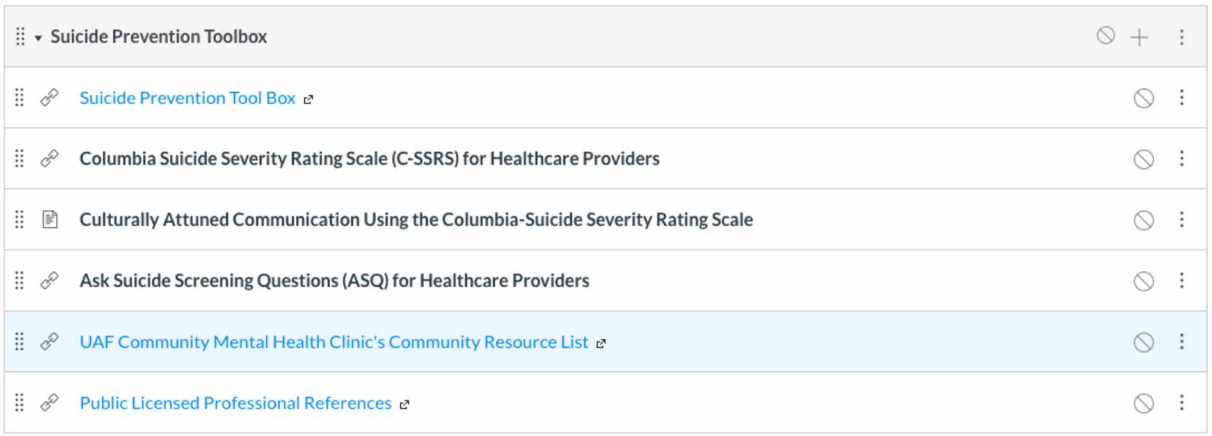
Suicide is a Journey Metaphor

When considering risk factors, it can be overwhelming and difficult to remember all of them. Especially when one is busy with intake and administration procedures. Working memory may be limited in a mental health crisis to recall all of the risk factors. Using a visual metaphor is one way to circumvent this issue (Alyami et al., 2016). In this metaphor, "Suicide is Like a Journey," the canoe represents the patient's risk factors, the other side of the river represent suicide, and the bridge on the Chena River represents life and psychosocial stressors. When the patient moves away from the bank of the river to travel to the other side of the bank (death by suicide), they have risk factors they take with them. This picture was created by a West Valley High School student, Ciara Pitka. She spent her winter break working on each piece. Ciara said she agreed to this request to create this piece of art since two students in her school died by suicide in 2018.



Suicide Prevention Tool Box

A resource center was created to support medical providers to incorporate this webinar into their medical practices. The suicide prevention tool box module includes a link to the C-SSRS for healthcare providers, a link to Ask Suicide Screening Questions (ASQ) for healthcare providers, a link to the UAF Community Mental Health Clinic's Community Resource List, and a link to Public Licensed Professional References in Fairbanks, AK. There are two handouts in the module: C-GIMS and an individualized, interpersonal, culturally-attuned modified version of the C-SSRS. In the suicide prevention tool box, there is a link to a Google Shared Folder titled "Suicide Prevention Tool Box" with additional national and local resources.



Google Shared Folder: Suicide Prevention Tool Box Link:

https://drive.google.com/drive/folders/1Zq4iZ9dQ7aGmPszfYhqhBFPodsVErii-

Training Evaluation

The final section is an evaluation for this webinar to improve future editions. Many of the questions were used for the evaluation from Phase Two and Phase Three of the development of "An Interpersonal Approach when Screening for Suicidality in Medical Settings." There are nine questions to evaluate this training.

Evaluation Form

Quiz Type	Graded Quiz
Points	0
Assignment Group	Assignments
Shuffle Answers	No
Time Limit	No Time Limit
Multiple Attempts	No
View Responses	Always
Show Correct Answers	Immediately
One Question at a Time	No

Question 1 0 pts

Today's session effectively addressed underlying processes of screening for suicide that influence validity.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neutral
- ○ Agree
- ○ Strongly Agree

Question 2 0 pts

Today's session effectively addressed underlying processes of screening for suicide that influence specificity.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neutral
- ○ Agree
- ○ Strongly Agree

Question 3 0 pts

I know the process behind choosing a screening measurement for my patients.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neutral
- ○ Agree
- ○ Strongly Agree

Question 4 0 pts

I know how to conduct a suicide risk screening with patients who appear to be at risk of dying by suicide.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neutral
- ○ Agree
- ○ Strongly Agree

Question 5 0 pts

The overall quality of the webinar was excellent.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neutral
- ○ Agree
- ○ Strongly Agree

Question 6 0 pts

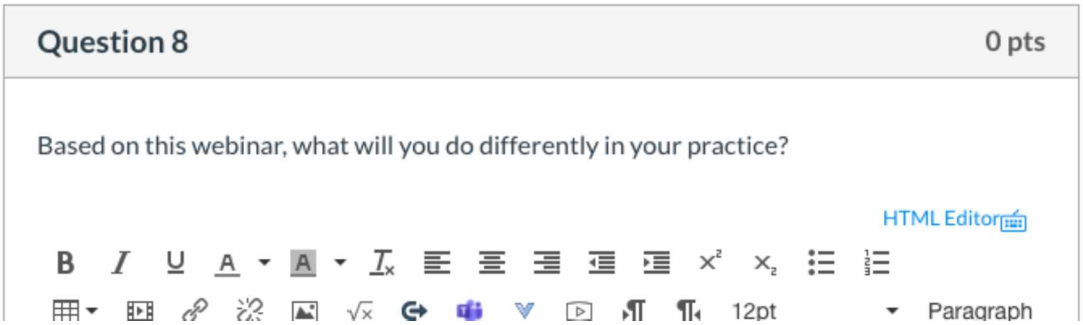
This webinar was relevant/valuable to my practice.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neutral
- ○ Agree
- ○ Strongly Agree

Question 7 0 pts

This webinar added to my clinical knowledge base.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neutral
- ○ Agree
- ○ Strongly Agree


Question 8
0 pts
Based on this webinar, what will you do differently in your practice?
HTML Editor
12pt
Paragraph


Question 9
0 pts
Comments:
HTML Editor
12pt
Paragraph